DOCUMENT RESUME

ED 258 730 PS 015 254

AUTHOR Hill, Brent Mathews
TITLE Effective Child Guidance: A Clinician's Guidebook.
PUB DATE [83]
NOTE 77p.; Developed as part of a Practicum, Nova University. For related documents, see PS 015 131 and PS 015 132.
PUB TYPE Guides - Non-Classroom Use (055) -- Dissertations/Theses - Practicum Papers (043)

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS *Consultation Programs; Counselor Role; Counselor Teacher Cooperation; Elementary Secondary Education; *Guidance; Humanistic Education; Inservice Teacher Education; Intervention; Postsecondary Education; Preschool Children; Preschool Education; *Prevention; *Psychoeducational Methods; *Teacher Role
IDENTIFIERS *Helping Behavior

ABSTRACT

Each chapter of this clinician's guidebook addresses a topic related to preventive mental health interventions with children. The first section discusses preventive services in terms of need, types, four approaches, and rationale. The second section reviews ways to effectively collaborate with the school system and provides discussion to help the clinician understand the school from participants' perspectives. The third section deals with preventive guidance that should and can be administered by a classroom teacher, specifically discussing teacher skills beneficial in developing classroom guidance, suggestions and resources for building needed skills, and guidance programs with which the clinician should be familiar and which the teacher may employ. The fourth section considers the use of the mental health professional in an educational role and discusses ways clinicians can maximize their existing skills and build their teaching skills. The fifth section deals with the practice of mental health consultation, reviewing its preventive nature and discussing types and stages of consultation. Ethical considerations are also briefly addressed. The sixth section deals with community intervention in the preschool population. Reasons for the neglect of the preschool/day care population in mental health promotion work, as well as methods for overcoming such barriers, are presented. The final section deals with specific problems confronting the prevention field, particularly funding and evaluation. Methods of approaching both these problems are outlined, and the importance of expanding the scope of prevention is emphasized. An extensive reference list concludes the document. (RH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

X This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

APPENDIX I

ED258730

EFFECTIVE CHILD GUIDANCE

A Clinician's Guidebook

B. Mathews Hill

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

B. Mathews Hill

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

PS 015254

TABLE OF CONTENTS

Prevention in Mental Health Services 1
Introduction 1
The Need for Preventive Services 1
Types of Prevention 1
Primary prevention 1
Preventive Approaches 2
Developmental approaches 2
Functional area approaches 2
Specific population approaches 2
Specific disorders approaches 2
The Rationale for Prevention 2
How to Use this Book 3

Collaboration with School Systems 4
Rationale for School Collaboration 4
Types of Collaboration 4
Understanding the School Environment 5

Training Educators as Guidance Leaders 8
Rationale 8
Appreciating Existing Skills 8
Building Helping Skills 9
Fitting the Curriculum 11
Specific Guidance Programs and Skills 12
Indications of Current Emotional Problems . . 12
Predictors of Future Emotional Problems . . . 12
Predictors of Psychological Symptoms and Substance Use 13
Predictors of future substance use or abuse areas 13
Affective Education 13
Rationale for Affective Education 13
DUSO 14
The Magic Circle 15
Classroom Meetings 17
Types of meetings 17
Social-problem-solving meetings 17
Open-ended meetings 17
Education-diagnostic meetings 17
Conducting meetings 18
Relaxation Training & Mental Imagery 19
Relaxation Training 19
Student preparation 20
Relaxation script 20

Guided Imagery 22
Student preparation 23
Audiotaping 23
Maturity 23
Guidance Activities 23
Georgia Comprehensive Guidance Series 24
Primary Guidance Activities 26
Bibliotherapy 27

The Clinician as an Educator 35
Rationale 35
Appreciating Existing Skills 35
Building Teaching Skills 37
Examples of the Clinician-Educator 37
TOPS 37
Other Projects 39

Consultation 40
History and Rationale 40
Roles and Responsibilities of the School Consultant 40
Types of Consultation 41
Case-centered consultation 41
Consultee-centered consultation 42
Program-centered consultation 42
Organization-centered consultation 42
Principles and Problems in Consultation 42
Stages in Consultation 43
Preliminary explorations 43
Negotiating a contract 43
Entry into the system 43
Diagnosis 43
Goal or objective setting 44
Exploration and selection of alternative intervention strategies 44
Implementation of intervention strategies 44
Outcome evaluation 44
Institutionalizing changes 44
Termination 44
Ethical Considerations 44

The Special Needs of Preschoolers 46
Rationale: The Neglected Millions 46
Barriers and Roadblocks to Intervention 47
Access and Familiarity with Day Care 47
Understanding the Day Care Environment 48
Types of Community Interventions 49
Preservice Training 49
Consultation and Inservice Training 49

Interventions into the Family 50
Therapeutic Preschool Approaches 50
Conclusion 52

Making Prevention Work 53
The Reality of Funding 53
Evaluation of Prevention Programs 54
Expanding the Umbrella 56
The Promise of Prevention 56

References 57

Prevention in Mental Health Services

Introduction

In 1978 Goldston stated that primary prevention is an idea whose time has come. Keller and Ritt (1983) caution that clinicians have often selected narrowly defined roles which unnecessarily limit their impact on the community. The purpose of this volume is to help clinicians expand their impact and put into practice an idea whose time has come.

The Need for Preventive Services

According to Berlin (1977) several studies indicate that there will never be sufficient numbers of mental health professionals to give treatment to the children who need it. Blai (1981) estimates that the number of children with some form of mental disturbance may approach 15% of the childhood population.

Caplan (1967), who is often considered the seminal thinker in the field concerning prevention of mental disorders, documents in his early works that psychological maldevelopment, maladaptation, and illness are so prevalent, that treatment of established cases can never be expected to deal adequately with more than a fraction of those which occur. The most efficient way to deal with this established need is community intervention which is aimed at preventing the occurrence of such problems.

Types of Prevention

Caplan (1967) has long advocated classifying types of prevention. He advocates a public health conceptual model which stresses primary, secondary, and tertiary prevention.

Primary prevention seeks to reduce the incidence of new cases of mental disorder and disability in a population. Secondary prevention aims at reducing the duration of cases of mental disorders that will occur in spite of primary prevention programs. Tertiary prevention seeks to reduce the community rate of residual defect which is often a sequel to acute mental illness. Tertiary prevention seeks to ensure that people who have dealt with their mental disorder will be hampered as little as possible in returning to full community participation.

This volume will address the area of primary prevention of mental disorders. The other two types of prevention are already within the scope of practice of most mental health professionals.

Preventive Approaches

Within the framework of primary prevention exists a myriad of different approaches. These can be loosely classified into four somewhat overlapping approaches: developmental, functional area, specific population, and specific disorder approaches.

Developmental approaches are those which utilize the expanding potential of the child. These approaches would include mental health promotion programs, affective education, maturation-centered and family-centered programs, as well as mental health education.

Functional area approaches seek to build competency in very specific areas of a person's functioning. With appropriate coping skills in place, the individual is then able to withstand disabling circumstances. Examples of such approaches would include stress management, lifestyle modifications, and building of skills for predictable life stresses. These might include hospitalization, starting school, or bereavement.

Specific population approaches emphasize the targeting of that population which is deemed to be at risk or easily accessible for preventive interventions. Groups such as children of disturbed parents, culturally deprived children, or elementary school students are examples of groups that have received such interventions.

Specific disorders approaches attempt to reduce the incidence of specific types of disorders, frequently related to physical problems. There are programs which seek to prevent fetal alcohol syndrome, mental retardation, or the developmental hazards that are experienced by the deaf or blind child. In addition, such functions as pre-kindergarten screenings, crisis intervention, mental health consultation, and programs dealing with the areas of divorce and separation would fall into this category.

The Rationale for Prevention

It can be seen from the preceeding sections that a clear cut case for preventive services exists. There is a large part of the population at risk which would benefit from such services.

A critical mass of information relating to primary prevention is in existence according to Goldston (1978). This information includes sufficient research to provide a solid knowledge base for program development.

The mental health clinician should be at the forefront in the development of prevention programs. Many mental health professionals shy away from this frontier due to a lack of adequate training in the area. This volume seeks to remedy that lack of knowledge.

How to Use this Book

Each chapter of this book addresses a category of preventive interventions. Each chapter also deals with children, for they are at the heart of any prevention program which seeks to be truly effective.

The second chapter deals with ways to effectively collaborate with the school system. Several types of collaborative efforts are reviewed. Three types of collaborations will be detailed individually in the subsequent chapters. A section to help the clinician understand the school as seen through the eyes of student, parent, and teacher is also included.

The third chapter deals with preventive guidance that should and can be administered by a classroom teacher. It includes understanding what skills the teacher may and may not have which would be beneficial in developing classroom guidance. Suggestions and resources for building needed skills are also included. The remainder of the chapter deals with specific guidance programs with which the clinician should be familiar and which the teacher may employ in the classroom.

The fourth chapter deals with using the mental health professional in an educational role. Included here are ways that clinicians can maximize their existing skills and build their teaching skills also.

Chapter Five deals exclusively and intensively with the practice of mental health consultation. Its preventive nature is reviewed and the types and stages of consultation are discussed. Ethical considerations are also briefly treated.

The sixth chapter deals with community intervention in the preschool population. The preschool/day care population has often been neglected in mental health promotion work. The reasons for this occurrence, as well as methods for overcoming these barriers, are also presented.

The final chapter in this volume deals with specific problems, such as funding and evaluation, that the prevention field has to deal with. Methods of meeting these obstacles, as well as expanding the impact of prevention, are also covered.

Collaboration with School Systems

Rationale for School Collaboration

Rutter (1979) estimates that prior to reaching adulthood, the child will spend nearly 15,000 hours in school. Next only to the family influence, school influences have generally been viewed as exerting tremendous power over a child's social and emotional growth.

The school has a proven role to play in the pursuit of mental health, Gilman (1981) has asserted. Couchman (1980) contends schools may actually be able to alter the value structures of communities. Both authors note that there is a potential for the schools to reverse the negative trends which have been established by poor neighborhood and family environments. This potential is not presently being realized.

What is needed to utilize this potential is collaboration between education and mental health services. Gilman (1981) has stated that the school is an effective setting for intervention, but its effectiveness is greatly magnified if it works in conjunction with the family and community. Where mental health services have collaborated with the schools, according to Legg (1980) the attention of both adults and children involved has shifted toward the importance of good mental health. Furthermore, it provides very practical ways for adults to help children handle their social and emotional problems.

Types of Collaboration

Current attempts at collaboration run the gamut from policy statements suggesting cooperation to in-school mental health centers. Most organized collaborative efforts fall somewhere in the middle of this continuum. Holliday (1979) found large urban areas to have been more suitable for school-based programs. Rural areas have tended to use a more adaptive or itinerant approach. Suburban areas tend to use a clinic-based mode of collaboration.

Barksdale (1979) initiated a prototypic mobile mental health service with an inner-city population. The project was a joint effort between the local schools and the local mental health agency. It successfully provided needed services to inner city students as well as their families.

Wax (1971) reviewed the achievements of a mental health preschool program. This cooperative education-mental health project provided both therapeutic as well as preventive benefits for the participants.

In 1981 Loewenstein described a mental health program for elementary students which was provided in the school setting by a mental health professional. Delivered in a group format, the Teaching Outreach Prevention School project has been viewed by participants as effective in promoting children's mental health.

A cooperative program to facilitate the needs of children placed in special education due to emotional or behavioral disorders was implemented by Barr and Delfava (1980). Since this population is normally a consumer of both special education programs as well as mental health services, such cooperation is both economical and in the best interest of the children. Their program also involves interagency cooperation with those other community resources that might prove helpful in meeting students' needs.

Holliday (1979) contends that many mental health professionals still conceptualize collaboration with schools according to traditional child guidance concepts. The traditional viewpoint favors collaborative interventions only at the individual or small group level. Holliday maintains that the organizational, community, and societal levels of collaboration are often neglected. This severely limits the types of interventions that are employed. The level of collaboration influences intervention strategy, skills required, funding, level of anticipated change, and the conceptualization of the service itself.

In reviewing the literature concerning collaborative school-mental health services, Barksdale (1979) found that the need for such programs was constantly highlighted. In this writer's review of the literature, three approaches were found to be the most common and feasible forms of collaboration. These three were: training educators as guidance leaders, using the mental health professional in an educative role, and employing mental health consultation. Each of these forms of collaboration will be discussed in detail in the ensuing chapters.

Understanding the School Environment

> "Workers trained in psychiatric principles and therapeutic techniques can best act as consultants to a nonpsychiatrically trained professional group if they first familiarize themselves with the attitudes and anxieties specifically related to the work and training of that group and the milieu in which that work takes place." (Parker, 1977, p. 186)

Education is an institution with a long history. The purpose of this section is not to detail that history. The noneducator needs to realize, however, that any institution with sufficient history will

develop its own norms, ideology, homeostasis, defenses, and resistances to change.

An example of the above is the office of principal. The schoolmaster or schoolmarm has existed for hundreds of years with minimal change in role expectations. The schoolmaster was responsible for the care of the building, the level of teaching, and appropriate discipline. The job description for the principal is essentially the same. Despite modern management theories, the principal studies to obtain his administrative credentials and he is expected by parents, teachers, and superintendents to fill an essentially authoritarian role.

Traditionally, school protocal dictates that any clinician visiting a school should check in at the office prior to visiting a classroom (Pressman, 1979). Pressman (1979) also suggests that the mental health practitioner should request a tour of the building, since principals take pride in their buildings and will feel the clinician is more familiar with the school's situation if they show him or her around. Principals may also have rules about teachers responding to telephone calls during instructional times.

Pressman further contends that if the clinician has familiarity with school schedules, reading programs, reasonable class size, etc., such knowledge will bolster the clinicians credibility with the school. One of the most common concerns expressed by teachers, in the author's experience, is the lack of understanding non-educators have concerning the functioning of schools.

Although there are exceptions, teachers have come to see visitations of principals and supervisory staff in "their" classrooms as threatening. Such visits have been linked to job security and other economic and professional issues. The consulting clinician needs to be careful not to resemble, either in behavior or purpose, the evaluating administrator.

Teachers are also skeptical of professional jargon that sounds too theoretical. Teachers have found that their undergraduate theoretical exposure in education did not provide a practical basis for teaching practice and they are, therefore, resistant to theoretical proposals. Teachers want something they can use in their classroom on Monday. Clinicians need to be careful in their approach to this demand, since teachers may not use on Tuesday what failed to work on Monday.

Mental health professionals need to be sensitive to territorial issues of teachers. To the teacher it is definitely "my class" or "my students". Since teachers are taught to be responsible for the academic and physical well-being, as well as the behavioral management of their students, an approach which intrudes upon that responsibility or authority will be resisted.

Parker (1977) contributed a great deal to the knowledge a school consultant or collaborator needs to have. He outlined several areas that tend to raise both the anger and defenses of teachers toward parents:

1. Parents who mistreat their children.
2. Mothers who put their relationships to husbands and boyfriends ahead of their responsibility to the child.
3. Parents whose value system differs markedly from that of the teacher's.
4. Parents who, for any reason, seem to "look down" on the teachers, or do not recognize their professional training.
5. Parents who, for any reason, criticize the school.

Clinicians would do well to be cognizant of these issues.

Training Educators as Guidance Leaders

Rationale

According to Muro and Dinkmeyer (1977) the teacher has access to real life situations in which their students must learn to cope with two basic life tasks - meeting the expectations of work and learning to relate effectively with others. Long (1970) holds that students are in need of a rehearsal for real life, or at least an innoculation for the stresses to come, in order to enhance their coping strengths. Tauss (1980) signaled the critical need for teachers to assume more guidance functions due to such external factors as budget cutbacks, lack of supportive personnel, and individualization of instruction.

Muro and Dinkmeyer (1977) note that in addition to the need for guidance which facilitates student growth, the teacher spends more time daily with the student than does any other professional. An educator proficient in guidance skills is able to maintain a balance in the classroom between educating and socializing the children. Such a classroom has the potential for enhancing self esteem, while administering logical consequences to assist the student in becoming a responsible member of society.

Many practitioners (Tauss, 1980; D'Augelli, Danish, Hauer, and Conter, 1980; Muro & Dinkmeyer, 1977; Koren, 1974; Long, 1970; Dinkmeyer & Caldwell, 1970) have provided excellent resources for helping teachers gain the necessary guidance skills. Several of the sections which follow also provide help or materials for the teacher desiring to enhance his or her guidance skills. In summary, the need and skills are present for classroom guidance, which Tauss (1980) contends is both possible and necessary.

Appreciating Existing Skills

A frequent blunder that mental health professionals make when entering a classroom is assuming the teacher lacks any guidance skills. This is not the case with most educators.

In general, teachers have many guidance skills which need to be recognized and appreciated by the mental health professional who wishes to be successful. Most elementary educators have a good grasp of developmental issues for the age group they are teaching. A good percentage of teachers are proficient at behavioral observation, and often more objective than parents (DSM III, 1980). In general, educators have the necessary skills to make basic assessments of a students' social, emotional, and intellectual functioning as well as the students' academic achievement. The questions teachers raise about students are seldom directed to finding the problem.

The questions concern the possible solutions. In general, teachers are dedicated to promoting the child's growth and development.

Building Helping Skills

Since most educators possess basic skills in the areas of child development, observation, assessment, and group management, the mental health practitioner would do well to concentrate in other areas. The specific helping skills the clinician can pass on to the teacher are those which have traditionally been associated with the field of counseling, i.e., active listening and reflecting responding.

Dinkmeyer and Caldwell (1970) have identified the act of conscious listening as the single most important competency in the area of guidance. They note that by the very nature of the elementary classroom, the teacher has frequent, although brief, occasions to employ listening skills.

Dinkmeyer and Caldwell (1970) have outlined several ways teachers can actively promote guidance through listening. These listening techniques include the "tell me" intervention, contact, constructive use of silence, and effective summary of content and feelings.

The "tell me" technique involves the teacher inviting the student to describe thoughts or feelings that the child is experiencing. The primary purpose of this method is to bring out feelings. This is done by attempting to sense the feelings that already exist within the child and to help the child express them adequately. In using the "tell me" technique teachers can be more successful if they skillfully employ feeling level words that tend to elicit an emotional response.

Contact is the phase of listening which communicates to the sender that the listener is paying attention. Although this skill seems an easy one to master, it is really quite involved. Typically a listener begins to frame answers to what is being said. At this point the listener is no longer receptive to what is being said. The contact technique requires eye contact, ear contact, mind contact, an ability to listen actively, and the willpower to avoid interruption.

The constructive use of silence as a listening skill is new to many teachers. Silence has usually been associated with either classroom management or study skills, but not with conversation. Yet silence can be a positive and comfortable experience during the active listening process. It provides time for self-evaluation as well as absorbing all that has been expressed. Thus a listener's desire to structure the interaction with constant verbal responses can prove to be counterproductive.

Summary at the end of an interaction can be beneficial to both sender and listener. It is usually most helpful to have the sender (student) summarize what has been said. If the teacher summarizes for the student, the latter is deprived of an opportunity to evaluate the communication and grow from the experience.

Since many teachers prefer step-by-step in-service and an opportunity to gain hands-on experience with new concepts, the clinician may want to consider a training program similar to that developed by D'Augelli et. al. (1980). This is a ten session, twenty-four hour inservice program. The program, which could be modified to meet local needs, takes the participant through seven stages or competencies, as follows:

Stage I: Nonverbal behavior: Eye contact. Body posture. Head and facial movements. Vocal quality. Distracting personal habits.

Stage II: Continuing responses (Content and Affective): Leading responses. Self-referent responses. Encouraging personal discussion. Remaining on the topic. Accurate. Concise. Encouraging personal exploration.

Stage III: Leading responses: Differences from continuing responses. Understanding the problem. Problem-solving strategies. Problem-solving responsibilities. Advice. Influencing.

Stage IV: Self-referent responses: Role changes. Self-disclosure. Modeling. Reinforcement, reassurance, coping strategies.

Stage V: Understanding your needs to be a helper: Power and control. Wanted, needed, depended upon. Be seen as competent and knowledgeable. Be admired, liked, approved.

Stage VI: Understanding others: Observing, hypotheses, testing hypotheses, expressing ideas. Description of strong, mild, positive, negative feelings. Description of topics by content centered on self, others, time, impersonal data.

Stage VII: Establishing effective helping relationships: Practicum for previously acquired helping skills.

Fitting the Curriculum

Each year the average teacher is bombarded with a new series of curricular requirements. A new reading series is adopted and the teacher is required to take inservice. The teacher's convention presenters give several ideas which need to be implemented the next Monday. A new school district supervisor has a "pet" area in which teachers will need to show improvement. A doctoral student is using several schools in the area to gain data for a dissertation. The principal wants an underdeveloped study area to receive more attention. The community, in response to local conditions, is demanding the school pay more attention to one area of the school program over other areas.

The unsuspecting, but well-intentioned, clinician who suggests anything that sounds like another curriculum area to the teacher is doomed to certain failure. To a burdened teacher more does not always equal better.

For a teacher to include items of a guidance nature into the regular curriculum, certain criteria usually need to be met:

1) The new program should not deprive students of their basic education in reading, mathematics, spelling, or language skills.

2) The programming must be congruent with the academic curriculum already in place. It must not be done instead of an existing area of study.

3) The teacher must receive sufficient hands-on training to feel competent in presenting the material to students.

The Georgia Comprehensive Guidance Series (1981), which will be reviewed later in this chapter, is an example of a system meeting these requirements. The Georgia State Department of Education was guided in the development of its program by the basic assumption that there is a guidance content in each subject area that all students should learn. Thus teachers using this program find that the guidance materials which they are using fit in to all of their subject areas, are well developed, practical, and easy to use. Extensive training and guidebooks are also available. Hauck (1978) developed a similar system for use with the primary grade student.

In summary, the consulting clinician would do well to avoid such words as "new" or "additional" when describing guidance materials. A more effective approach would be to demonstrate how guidance curriculum could enhance, supplement, or upgrade the present curriculum while increasing the student's social survival skills or affective growth.

Specific Guidance Programs and Skills

Indications of Current Emotional Problems

Educators vary in their ability to recognize indicators of current emotional problems. Two models for detecting such problems are particularly appropriate for the practicing teacher.

Mansheim (1982) advises teachers that generally abnormal behavior is either too much or too little of an otherwise normal behavior. The author suggests that if a child shows a marked shift toward too much or too little of a behavior in the areas of self-concept, peer relationships, academics, health, grooming, and family life that educators should be alert to the possibility of emotional problems. In the preschool child, emotional problems are most often characterized by anxiety types of reactions. In the school-aged child, most of the warning signs are forms of behavioral disturbance with the origin most commonly being found in family problems.

Loveless (1981) has pointed out several "red flags" educators can use to detect the possibility of problems:

1) Excessive anxiety.
2) Inability to use intellect efficiently.
3) Inappropriate emotional responses for the situation.
4) Inappropriate behavior for the age of the child.
5) Perceptual distortions. (Persistent, inaccurate and abnormal perceptions of the world of objects and facts.)
6) Highly defensive behavior.
7) Inadequate self-concept.
8) Inflexibility.
9) Distorted patterns of movement.
10) Impairment of emotional relationships.

Predictors of Future Emotional Problems

Many educators and mental health professionals are unaware of the Woodlawn longitudinal study which pinpoints several early childhood predictors of later psychological symptomology and substance use (Kellam, Brown, Rubin, & Ensminger, 1982).

Predictors of Psychological Symptoms and Substance Use (Kellam, et. al., 1982)

- Hyperactivity in males tends to predict a more restless, nervous, tempermental, or depressed adolescent or adult.
- Early cheerlessness or depression in males is often an antecedent of schizophrenia.
- Early worrying and nailbiting, together with specific fears in childhood are predictive of adult anxiety disorders for both sexes.
- The young female who simultaneously experiences sadness and worry will later tend to report several psychological symptoms of significant severity.
- Somatic (physical) symptoms and muscular tensions are related to adult problems of a similar nature for both sexes.
- Early learning problems (without behavior problems) is associated with depression in older males and paranoid feelings in older females.
- A low I.Q. is predictive of future neurotic problems in females and of antisocial problems in males.
- Early aggressiveness, together with antisocial behavior, is predictive of sociopathic problems for both sexes and predictive of schizophrenia for the male.
- Pathological lying and staying out late is predictive of sociopathic problems in later life for both males and females.
- Theft and sexual problems in the young female are associated with later sociopathic problems.

Predictors of future substance use or abuse are:

- Psychological distress in early childhood is predictive of future substance use.
- Alienation from the dominant values of society in middle childhood is linked to later substance use.
- Children seen as obedient, tender, and shy rarely engage in later substance use.
- Early aggressive and antisocial behavior is indicative of later substance use.
- The rare combination of the shy and aggressive young male is highly predictive of future substance use.

Affective Education

Rationale for Affective Education

Educators of young children have long prided themselves on teaching the whole child. This concept encompasses the belief that children learn best in an environment which promotes social and emotional growth as well as cognitive growth.

Yet many of these same educators find it difficult, with current curricular practices, to deal in any sort of systematic or rational way with the social and emotional aspects of the student's learning. The reading, math, and science texts don't provide an answer. The health text might provide a short chapter on feelings, but little else. Some educators attempt to develop their own programs in their so called "spare" time.

Affective education models and programs have emerged in response to this need. They encompass learnings related to dealing with feelings, resolving conflicts, and relating to others. Indeed, Buchholz (1974) noted that cognitive and affective education can be mutually supportive since affective education can assist children in dealing with emotions that interfere with academic achievement.

Buchholz (1974) also noted several other advantages that can accrue as a result of using an affective curriculum. It promotes creative thinking and self-control. Buchholz also noted that teaching style can be positively impacted as a teacher learns to be more empathic.

There have been several affective education programs employed throughout the United States. It is beyond the scope of this guidebook to review them all. Instead, two of the most popular comprehensive programs will be reviewed. This will give a flavor for what these types of programs are like. Additional suggestions will follow the reviews.

There are two widely used comprehensive affective education programs that every elementary educator should be familiar with. One is the Human Development Program's "Magic Circle". The other program is Don Dinkmeyer's DUSO.

DUSO

Author: Don Dinkmeyer, Ph.D. (1970)
Available from: American Guidance Service, Inc.
Publisher's Building
Circle Pines, Minnesota 55014

DUSO is an acronym for Developing Understanding of Self and Others. It is a self-contained set of instructions, activities, posters, tapes, and songs that lead the kindergarten and primary-aged child on a journey of affective discovery.

Because these kits (DUSO D-1 and D-2) are so comprehensive, the educator can usually begin to use them in the classroom after a careful reading of the manual. Many educators feel more comfortable using DUSO after some counselor led or teacher led inservice and a demonstration lesson or two.

The DUSO curriculum is organized around eight basic themes which comprise its units:

I. Understanding and Accepting Self
II. Understanding Feelings
III. Understanding Others
IV. Understanding Independence
V. Understanding Goals and Purposeful Behavior
VI. Understanding Mastery, Competence, and Resourcefulness
VII. Understanding Emotional Maturity
VIII. Understanding Choices and Consequences

Most educators who are familiar with DUSO and are comfortable with its presentations use the curriculum daily. Since there is great variety in the types of activities provided, it is relatively easy to maintain student interest. Some educators, however, prefer to use a more selective approach using specific topics according to class needs.

DUSO activities are done as a group and several helps are given to help maintain appropriate group behaviors. A simple opening and closing song allow the child a clear grasp of when s/he is involved in an affective educational activity rather than a cognitive assignment.

One of the hallmarks of the DUSO approach is its use of puppetry. The program's central character is DUSO, a puppet dolphin. DUSO's sidekick is a puppet known as Flopsie the Flounder. The instructions in the manual provide an effective rationale for the use of puppetry as well as several practical "how to" suggestions for the educator.

Although puppetry is employed in each of the cycles of the program, it is only one of the major elements of the program. In addition to the puppetry, the program makes major use of group discussions, stories, songs, problem situations, and role playing activities.

DUSO has been extensively field tested and research continues to be done around the use of the program. For many educators who are searching for a comprehensive and complete program, DUSO may be the light at the end of the tunnel.

THE MAGIC CIRCLE

The Human Development Program
Published by: Human Development Training Institute, Inc.
7574 University Avenue
La Mesa, California 92041

The Human Development Program (HDP) is commonly referred to as "The Magic Circle". The "magic" label refers to the fact that it deals in the affective rather than the cognitive area of learning. The circle refers to the logistical formations of the group that is involved in the process.

The HDP is a sequential affective curriculum designed to promote preventive mental health by focusing on emotional and social development. The program design itself and its sequential format are the product of years of research and field testing.

The program focuses on three general themes: (a) awareness, (b) social interaction, and (c) mastery. Each of these themes is developed at each age or grade level by a series of topics discussed by students in a circle group with the teacher serving as the leader or catalyst.

The circle time is generally around twenty minutes per group. During the twenty minutes, the leader will typically introduce the topic to be dealt with. The leader then assumes a more facilitative role by helping the children focus on feelings, promoting active listening in the group, reflecting back the feeling-level messages made by students, enforcing rules against hostile or destructive interactions, and reviewing and synthesizing the material dealt with as the group culminates.

Each level is comprised of topics specifically suited to the level of the students involved. In the guide used in the first grade topics include such things as "Having nice feelings and bad feelings, too", or "Some things at school that I can do for myself".

The activity guides for each grade or age level comprise one component of the program. The basic curriculum also consists of the HDP Theory Manual and the volume "Magic Circle": An Overview of the Human Development Program. (The overview is also available on microfiche from ERIC's Resources in Education as ED 148 694.)

Teachers often express concern that they are not adequately trained to lead a semistructured affective education group. Although the program does not require an extensive background, there are some problems in going into the curriculum unknowledgeable. One of the program's developers, Dr. Uvaldo Palomares, told a group of educators attending the 1976 Utah Education Association convention that some untrained group leaders decided to invent several of their own topics. This resulted in some public dissatisfaction with the program in the schools.

Educators should become very familiar with the theory behind the program before using it. Minimal preparation would include a thorough reading of the theory manual. Most educators find they perform more adequately if they have had inservice training and demonstrations of the program.

The authors of the Human Development Program clearly state that their program is not a panacea or a behavior modification program. Research has, however, generally been favorable about increases in positive, creative, and healthy behaviors for participants. These factors, coupled with the relatively inexpensive costs to use the program, make it an attractive affective education curriculum for today's

Classroom Meetings

Dr. William Glasser (1969) has pioneered the use of the classroom meeting as both an affective and cognitive learning tool. The classroom meeting is less structured than the DUSO or Magic Circle programs but there are some recognizable similarities.

Dr. Glasser has outlined three types of classroom meetings. They are social-problem-solving, open-ended, and educational-diagnostic meetings. Although each meeting has a similar operating format, each is different in what it focuses upon.

Types of meetings. The social-problem-solving meeting attempts to solve individual and group educational problems affecting the class or the school. The open-ended meeting is an attempt to use a semistructured group setting to stimulate students to think. Students are also asked to relate what they know to the subject being discussed. Educational-diagnostic meetings are directly related to what the students are studying. They act as a barometer to see whether or not certain teaching procedures used in the class are effective.

Social-problem-solving meetings. In such meetings it is essential that certain guidelines be followed:

(1) All problems relative to the class as a group and to any individual in the class are eligible for discussion.
(2) The discussion itself should always be directed toward solving the problem and not toward fault finding or deciding punishment. This helps children learn to think in terms of a solution to problems rather than blame. It is the only positive way to approach true problem-solving.
(3) Meetings should be conducted in a tight circle. This allows everyone equal opportunity for visual and verbal contact.

Open-ended meetings. These are similar to class discussions except that they are less structured. The educator is not specifically looking for factual answers but instead attempts to take children from the basic, with which they are familiar, and have them apply higher levels of thinking to the subject.

Education-diagnostic meetings. These are often the hardest meetings for the educator to conduct since the aim is to discover weaknesses in the student's understanding (and not just their memorization) of the current subject matter. This type of meeting seeks to induce questioning and discussion about a subject between the students themselves. The educator attempts to have the students gain a working, living, and relevant picture of the content rather than a mastery of the facts alone. By not incorporating correction and value judgements during the meetings the educator can more clearly "test" the students' understanding of the subject matter.

Conducting meetings. Since the techniques used in classroom meetings are seldom taught in teacher education programs, few teachers possess the skills to immediately implement such a program. Most teachers need some inservice training, observations of meetings, and opportunities to co-lead a class with a more experienced practitioner. Glasser (1969) has suggested several steps for the school wishing to start and maintain such a program:

(1) The philosophy behind the concept of classroom meetings needs to be discussed and understood by the faculty.
(2) An experienced educator familiar with the use of the meetings demonstrates them for individual teachers and the whole faculty.
(3) Educators need to understand that the circular seating arrangement is the most facilitative arrangement there is. They will need to look for ways to make a rapid shift from the regular seating arrangement to the circle formation of chairs.
(4) Teachers should sit in a different place in the circle each day. Children who need to be separated may be separated without causing a problem with the process.
(5) Beginning practitioners should consider teaming with a person more experienced in holding meetings.
(6) Disciplinary meetings should not be repetitive. This tends to be counterproductive. However, when important disciplinary problems arise there should not be any reluctance to openly deal with them in the meetings.
(7) Duration of meetings in the primary grades should not be any longer than 10 to 15 minutes. Intermediate grades may have meetings up to 30 minutes in length and secondary students may even extend the time beyond 30 minutes.
(8) Most students work best with the opportunity of recognition given to those raising their hand. The teacher may want to give those who choose not to raise their hand the chance to contribute as well.
(9) The leader should not interrupt a child to correct bad grammar, bad usage, or mild profanity since this may tend to stifle contributions from that child as well as others.
(10) The never ending commentary of the talkative child should be interrupted after a reasonable period with statements such as, "We'd like to go on to someone else. We'll come back to you in a little while". Such statements help the class but don't hurt the child.

(11) Class meetings may result in a child relating some very personal material. Keeping in mind that adult (teacher) anxiety in these matters is usually much higher than the students' anxiety, it is often best to listen to the material and learn more about the student.

Relaxation Training & Mental Imagery

Koeppen (1974) has noted, and most educators would agree, that students will experience some degree of tension at one time or another during their early school years. The degree of tension experienced will vary from mild to severe. The causes may range from lack of knowledge in a given subject to test anxiety or extreme parental pressure.

Relaxation training and mental imagery practices are two techniques that can be used to deal with this tension as well as provide a self-enhancing skill for the student to use throughout a lifetime of meeting stressful circumstances. The purpose of this section is to provide the clinician with the background necessary to train teachers in the use of these two techniques.

Relaxation Training

Although relaxation training often employs the use of mental imagery, the reverse is not necessarily true. Therefore, each of these techniques will be discussed separately.

Relaxation training has been used extensively since Wolpe (1958) first noted that relaxation inhibited the anxiety response. Since that time its use has expanded to helping individuals deal not only with anxiety but phobic reactions, stress management, pain control, natural childbirth, and hyperactivity.

Once children have learned the skills involved in relaxation, they will be able to use them even when an instructor is not present. Thus they will have learned a skill they can keep and use for a lifetime. Rossman and Kahnweiler (1977) have also noted that trained children begin to discriminate between a tension state and nontension states in their everyday functioning.

Many educators are interested in the use of relaxation training with hyperactive students. Dunn and Howell (1982) experimented with the use of relaxation training for elementary-aged hyperactive males. They found these types of children could be taught relaxation in several ways and that short-term positive effects were readily observable. Redfering and Bowman (1981) also noted similar observable benefits in using relaxation with behaviorally disturbed young children.

Student preparation. In preparing students for relaxation training it is essential that the adult leader have a firm grasp of the process. This is accomplished most efficiently by the instructor undergoing relaxation training prior to instructing the students. A script similar to the one that follows could be taped and used by the educator and then used again later with the students. If the educator has questions or concerns about relaxation training, most counselors are familiar with the process and could act as a helping consultant.

Since young students are unfamiliar with the adult verbalizations used to describe tension, a simple demonstration is usually a good initial step. Have the children bend their wrists upward like a police officer would to stop traffic. Have them hold this position for a minute or two. Then have them let their hand rest. Repeat this a few times and the students will gain a better understanding of the concepts of tension and relaxation.

Once this concept is experienced the educator needs to briefly describe what the process of relaxation training is to the students. Depending on the age of the child the educator may need to simplify or expand the explanation. The teacher may tell younger students that they are going to do a relaxing game. This is a game they can use when their bodies don't feel good or have tight feelings. Older children can be told more explicitly what relaxation training is and have their questions answered about the process. A common misconception with older children is that relaxation is hypnosis. While relaxation is used in hypnosis, it is not a form of hypnosis.

Relaxation script. What follows is one of many varieties of scripts developed by the author to help children learn to relax.

> Now get yourself in a comfortable position, laying on the floor with all of the parts of your body touching the floor, your hands, your head, your feet, and your back. Take two deep breaths in, let them completely out....now, I want you to begin to play an imagining game with me. A game where your body is going to become very loose, very heavy, and very comfortable, like it was a rag doll. Now, just let all of the muscles of your body get very, very, very tight. Tighten up the muscles of your face. Tighten up the muscles of your hands. Tighten up the muscles of your feet and hold them tight. Hold them. Hold them. Now let all of them go untight. Just flop down. Now...the feelings that you are feeling right now are relaxation feelings. We're going to go through and do that with each of the muscles of your body so that they can become relaxed. But they

have to know the difference between being relaxed and not being relaxed, so we're going to tighten each one of them up and then we're going to let each one of them get very flippy-floppy and loose. Now, lets start down at the bottom of your body with the toes. Make your toes go very, very tight inside your shoes so that they are pressing against the bottoms of your shoes...so that your whole foot feels very, very tight because your toes are pushing against your shoes. Now...let your toes just relax and take a little rest, and notice how they feel different now than they did before. Now... I want you to tighten up some other muscles in the bottom parts of your legs. I want you to move your toes so that they come closer to your head, and feel how the muscles in your lower leg get very, very tight when your toes start pointing up towards your head. Now let all of those muscles relax and feel the different feelings that those muscles in your legs have. Feel those different feelings. Now, I want you to make the muscles in the top parts of your legs go tight. You might even need to make all of the muscles in all the parts of your leg go tight. Keep them tight. Now let them go loose so that they are heavy and kind of have a warm and comfortable feeling in them. Now, I want you to think and kind of pretend to yourself that someone was going to hit you in the stomach, and so you had to tighten up your stomach really tight so that it wouldn't hurt. Tighten up all of the muscles of your stomach, like if someone was going to hit you. And hold it. Hold it for a few seconds. Now let your tummy go loose, so that you can feel those same warm feelings in your toes, in your legs, and in your tummy. Now, let the muscles of your chest tighten up. Hold them tight. Then let them go loose and feel how warm and comfortable they feel, with each and every breath that you take. Now, pull your shoulders up so that they are very, very close as they can get to your ears and feel how tight your shoulders feel. Hold your shoulders up real high so that they're close to your ears and then just let them relax back down the way they normally would be. Feel the difference in how your shoulders feel. Now, I want you to make a fist in both hands and tighten up every muscle in your entire arms so that they feel very, very tight, as if you were going to have to hit someone. Feel how tight they feel. Hold the

fist tight...squeeze, squeeze, tight. Now let your hands and your arms relax, so that now most of the parts of your body just begin to feel that nice, warm, tingling feeling. Now, while you're laying down and your eyes are nice and closed I want you to make a face like you would make if you had just eaten a very, very sour lemon. Squeeze all of the muscles of your face very close together, like you just had a lemon. Hold your face like that. Now, let your face relax so that the muscles of your face, and of your shoulders, and of your arms, and hands, and the muscles of your tummy, and legs, and feet, and toes are all beginning to get very, very heavy, very, very warm and very, very comfortable. Let your mind feel all of those warm, comfortable feelings. Think how each muscle feels as it's just laying there...comfortable.... relaxed....warm....and tingly. And let each and every time that you breathe make your body feel more and more relaxed....more and more relaxed.

Now in just a few moments we are going to go back to our regular way of feeling with our bodies, but you have learned a new way that you can make your body very relaxed and very comfortable and you can use this at your home or at other times when you need to. Now, as soon as you want, you can start wiggling some of the muscles of your hands and of your fingers and then the rest of your body until your whole body feels the way that it regularly does, and as soon as you do that you can get up and go back to your seat.

Guided Imagery

Guided imagery techniques are generally suitable and beneficial for all children who are in touch with reality.

Educators have found that imagery techniques can be used to increase intuitive and creative expression, increase motivation to learn, and teach children to better understand and manage their emotions. The guiding of the imagery by the educator helps to create a sense of security for the student as well as a sense of direction for the educator.

By using imagery the students can try out new, more effective behaviors. Students can also imagine themselves handling strong emotions such as anger in a socially appropriate manner.

Imagery can also be used to increase a student's self-awareness. Students can go on an imagery journey through their own minds or bodies. By shrinking to the size of a speck of dust the student can experience tense neck muscles or an anxious stomach from a new perspective.

As with relaxation training, it is helpful for the educator to first experience the use of imagery before employing imagery in the classroom. Imagery occurs more freely if the child is relaxed but imagery can also be used to help facilitate relaxation.

Student preparation. Educators should explain to students that they are going to participate in creative or imagination games. The term "fantasy" should be avoided since in some circles fantasy carries with it some negative or inappropriate connotations.

Educators may want to preview the imagery for the class in addition to discussing it afterward. This tends to demystify the process for the child and may facilitate greater involvement in the process.

Audiotaping. Although audiotaping of relaxation scripts was recommended previously, the same does not hold true for an imagery experience. The leader needs to be very much aware of the pace and nonverbal cues of the group. Modifications and adjustments as to timing and content must be tailored to the needs of the participants.

Maturity. The age of the class needs to be taken into account in structuring an imagery experience. For instance, although four year olds can successfully follow simple and familiar directions for an active imagery experience, complex or novel directions are ineffective for young children. Between the ages of six and eight, children begin to be able to incorporate more complex and novel directions and imagery.

An easy and appropriate way to gauge the level of complexity to use with your students would be to solicit the children's current fantasies. This information has the added benefit of providing a means for the leader to incorporate already existing fantasies into the imagery experience.

Guidance Activities

Guidance activities are those that help prepare a child to live successfully within his society. A basic premise of using this type of model in the basic curriculum is that every content area in the schools has a guidance component that can and should be taught simultaneously with the academic concepts.

The difference between guidance activities and affective education is important to make, although the two models are compatible. The affective curriculum is often comprehensive in and of itself and deals with the areas of self-understanding and dealing with emotions. Guidance activities tend to "piggyback" on these areas within the academic curriculum (reading, social studies, etc.) and focus on several areas of social functioning in addition to feelings.

Most guidance activities are teacher made extensions of the day's lesson that involve the child in increased learning about how he or she functions within society. Some school districts and state boards of education have compiled and categorized these activities to assist educators in incorporating them into the academic curriculum.

The compilers of such programs usually stress that guidance activities work best when there is a match between the activity and the educator's teaching style. This is done by the educator either adapting previously used activities or inventing his own activities within a broad conceptual framework.

What follows are short reviews of two comprehensive guidance activity programs:

Georgia Comprehensive Guidance Series

Sponsor: Georgia Department of Education, Atlanta, Georgia 30334
in conjunction with the University of Missouri at Columbia.

By far the most comprehensive guidance program surveyed is the Georgia Comprehensive Guidance Series. This series includes activity guides for students K-12. The series also includes a program planning guide, a staff development curriculum, and a comprehensive curriculum guide.

This program holds that developmental guidance contains certain philosophical bases or assumptions:

Assumption 1: Guidance should help develop and protect students' individuality.

Assumption 2: Guidance program should be available to everyone at all levels.

Assumption 3: Guidance should meet developmental as well as remedial needs.

Assumption 4: Guidance should be integrated into the total educational process.

The developers have outlined eight broad areas of human growth that guidance programs can help develop. These eight areas are:

(1) Self-understanding.
(2) Interpersonal relations.
(3) Expression of ideas.
(4) Gathering and processing information.
(5) Rights and responsibilities.
(6) Valuing and decision making.
(7) Achievement motivation.
(8) Problem solving.

Development within these areas helps the student function in the basic life roles of learner, individual, citizen, consumer, and producer.

The originators of this series note that there are three different methods educators use in gaining guidance curriculum materials. These are adopting, adapting, and creating.

Adopting. This is the process whereby the educator avoids "reinventing the wheel". Since many national, state, and local projects have been developed there may be many materials that share the same goals as the educator has.

Adapting. This is the process an educator uses when guidance materials are suitable in some of their dimensions but not in all areas. The educator then alters the material in some of these dimensions (e.g., age level) before using it.

Creating. This is the process the educator uses when certain goals are in mind but materials are not in hand. It involves outlining what students need to learn, organizing resources and activities, and identifying standards for evaluation of learning.

The series also gives directions for educators wishing to write their own guidance activities.

Samples of activities for elementary aged children are included in Appendix A of this guidebook.

The various guides connected with the Georgia Comprehensive Guidance Series are also available on microfiche from the ERIC Document Reproduction Service by the following access numbers:

ED 222 784 Program Planning Guide.
ED 222 785 Staff Development Guidance Curriculum.
ED 222 786 A Comprehensive Guidance Curriculum for Elementary and Secondary Schools.

ED 222 787 Kindergarten Activities Guide.
ED 222 788 Second Grade Activities Guide.
ED 222 789 Third Grade Activities Guide.
ED 222 790 Fourth Grade Activities Guide.
ED 222 791 Fifth Grade Activities Guide.
ED 222 792 Sixth Grade Activities Guide.
ED 222 793 Seventh Grade Activities Guide.
ED 222 794 Guidance Curriculum Methods Guide for Secondary Schools.

Primary Guidance Activities

Sponsor: South-Western City School District, 465 Kingston Avenue, Grove City, Ohio 43123 (614/875-2318)

This program was designed for educators serving in the primary grades. It attempts to integrate the seven broad developmental areas of: (1) individual and environment; (2) world of work; (3) self; (4) economics; (5) educational training; (6) employability/work adjustment; and (7) decision making.

These seven broad areas are taught through activities covering thirty-five topical areas. The thirty-five areas are:

(1) capabilities
(2) changes
(3) cooperation
(4) criticism
(5) differences
(6) family
(7) feelings
(8) free time
(9) friends
(10) following directions
(11) handicaps
(12) honesty
(13) improving environment
(14) kindness
(15) magic circle
(16) materials
(17) patience
(18) paying attention
(19) problem solving
(20) rejection
(21) responsibility
(22) role playing
(23) rules
(24) school phobia
(25) school relevancy
(26) self acceptance
(27) self control
(28) self importance
(29) senses
(30) sharing
(31) social skills
(32) strangers
(33) tattling
(34) values
(35) work habits

Although these thirty-five areas appear inclusive the compiler has included an extensive index which refers the reader to areas where very specific topics are included. Other user helps include a book list for thirty-three of the areas, a section on guidance activity materials, and directions for using the "Magic Circle" program.

Most of these activities were developed by educators with minimal training in the area of guidance. They are usable and modifiable. The fact that these activities were teacher made or teacher modified should encourage other educators to develop their own original guidance activities.

Sample activities from this program are included in Appendix B of this guidebook.

The full text is available on microfiche as ERIC Document Reproduction Service Number ED 156 866.

Bibliotherapy

Bibliotherapy is a term used to describe the occurrence of positive outcomes when a child with a specific need interacts with a book, record, or videotape that has the potential to meet that child's need. Bibliotherapy has had a long history of use by counselors with problem students. Recently many educators have seen the value of "prescribing" and "debriefing" certain books with their nondisturbed students who might benefit from the content.

Bibliotherapy for the child in crisis or the troubled student is still best left in the hands of the counselor. However, the educator who is familiar with the students' lives and with the books on the library shelf can make a tremendous positive impact upon the child.

Many teachers have been using these concepts for years. At the first of the school year, many primary grade teachers read such stories as The Boy Who would not go to School or Miss Nelson is Missing in order to ease the children's fears or impact behavior.

The greatest precaution that needs to be stressed is the educator's familiarity with the book and the child. Some books on a general topic may be written in a way that a particular child reading them might actually experience a reduction in motivation or self-esteem or possibly a heightening of fear. Children who already show symptoms of problems should be discouraged from books that might exacerbate the symptom. For example, a child with a problematic use of fantasy should not be encouraged to read such books as Where the Wild Things Are.

What follows is a listing of books divided into the guidance areas they touch on. Familiarity and wise use of these resources can result in positive growth and development for young children.

Capabilities.

All by Myself. Jane B. Moncure, Elgin, Ill.: The Child's World, 1976.

Everything Changes. Morris Philipson, New York: Random House, 1972. (Identity/changes)

I am Loveable and Capable. S. Simon [illegible]es, Ill.: Argus)

Once a Mouse. Marcia Brown, New York: Charles Scribner's Sons, 1961. (Self-acceptance)

The Terrible Thing that Happened at Our House. Marge Blaine, New York: Parents Magazine Press, 1975. (Changes)

Tico and the Golden Wings. Leo Lionni, New York: Pantheon, 1964.

What Every Kid Should Know. J. Kalb and D. Viscott, Houghton Mifflin, 1976. (Self-concept)

Death

The Accident. Carol Carrick, New York: Seabury, 1976. (Pet death)

The Big Wave. Pearl S. Buck, New York: John Day, 1948.

The Bird's Last Song. Judith Liberman, Menlo Park, Calif.: Addison-Wesley, 1976.

The Dead Bird. Margaret W. Brown, New York: Young Scott Books, 1965.

Death is Natural. Laurence Pringle, New York: Four Winds, 1977.

Growing Time. Sandol Stoddard Warburg, Boston: Houghton Mifflin, 1969.

Life and Death. Herbert Zim and Sonia Blecker, New York: William Morrow and Company, 1970.

The Magic Moth. Virginia Lee, New York: Seabury, 1972.

My Grandson Lew. Charlotte Zolotow, New York: Harper & Row, 1974.

A Summer to Die. Lois Lowry, Boston: Houghtin-Mifflin, 1977.

Talking about Death. Earl A. Groliman, Boston: Beacon Press, 1970.

A Taste of Blackberries. Boris Buchman, New York: Thomas Y. Crowell Company, 1973.

Where the Red Fern Grows. Wilson Rawls, New York: Doubleday and Company, 1961. (Pet death)

Why did Grandma Die? Trudy Madler, Milwaukee: Raintree, 1980.

Why did he Die? Audrey Harris, Minneapolis: Lerner, 1965.

Differences.

Crow Boy. Taro Yashima, New York: Viking Press, 1955.

The Five Chinese Brothers. Clair H. Bishop and Kurt Wiese, New York: Coward, McCann & Geoghegan, 1938.

Divorce.

The Boys and Girls Book about Divorce. Richard Gardner, New York: Bantam, 1970.

Daddy. Jeannette F. Caines, New York: Harper & Row, 1977.

A Girl Called Al. Constance C. Greene, New York: Viking Press, 1969.

I Won't Go without a Father. Muriel Stanek, Chicago: Albert Whitman & Company, 1972. (Single parent)

Me Day. Joan M. Lexau, New York: Dial Press, 1971.

My Dad Lives in a Downtown Motel. Peggy Mann, New York: Doubleday & Company, 1973.

A Part of the Dream. Eve Bunting, Mankato, Minn.: Creative Education, 1978.

Where is Daddy? Beth Goff, Boston: Beacon Press, 1969.

Will Dad ever Move Back Home? Paula Z. Hogan, Milwaukee: Raintree, 1980.

Cooperation.

A Bargain for Frances. Russell Hoban, New York: Harper & Row, 1970. (Friends)

Dr. Gardner's Fairy Tales for Today's Children. Richard Gardner, Englewood Cliffs, N.J.: Prentice-Hall, 1974.

The Poppy Seeds. Clyde R. Bulla, New York: Thomas Y. Crowell, 1955. (Sharing)

Swimmy. Leo Lionni, New York: Pantheon, 1963.

Emotions.

The Boy With a Problem. Joan Fassler, New York: Behavioral Publications, 1971.

Caring. Jane B. Moncure, Elgin, Ill.: The Child's World, 1980. (Empathy)

Dr. Gardner's Stories About the Real World. Richard Gardner, Englewood Cliffs, N.J.: Prentice-Hall, 1972. (Conflicts)

Don't Worry Dear. Joan Fassler, New York: Behavioral Publications, 1971. (Insecurity)

I Feel: A Picture Book of Emotions. George Ancona, New York: E.P. Dutton, 1977.

If I Had My Way. Norma Klein, New York: Random House, 1974. (Attention)

I Hate Boys/I Hate Girls. Paula Z. Hogan, Milwaukee: Raintree, 1980. (Changes)

I Have Feelings. Terry Berger, New York: Behavioral Publications, 1971.

I Never Say I'm Thankful, But I Am. Elgin, Ill.: The Child's World, 1979.

Island of the Blue Dolphins. Scott O'Dell, Boston: Houghton Mifflin, 1960. (Loneliness)

Jane's Blanket. Arthur Miller, New York: Crowell-Collier, 1963. (Dependence)

Kindness. Jane B. Moncure, Elgin, Ill.: The Child's World, 1980.

Love. Jane B. Moncure, Elgin, Ill.: The Child's World, 1980.

Snaffles. Steven Cosgrove, Mankato, Minn.: Creative Education, 1980.

Sometimes I Like to Cry. Elizabeth and Henry Stanton, Chicago: Albert Witman, 1978. (Sadness)

T.A. for Kids. A. Freed, Sacramento, Ca.: Jalmar Press, 1971.

T.A. for Tots (and other Prinzes). A. Freed, Sacramento, Ca.: Jalmar Press, 1973.

What Does it Mean? Sad. Sylvia R. Tester, Elgin, Ill.: The Child's World, 1980. (Sadness)

What Makes Me Feel this Way? Growing Up with Human Emotions. E. LeShan, New York: Collier, 1972.

Fears.

Bedtime for Frances. Rusell Hoban, New York: Harper & Row, 1960. (Darkness)

The Don't Be Scared Book. Ilse-Margaret Vogel, New York: Atheneum, 1964. (General)

Now I Know. Julius Schwartz, New York: McGraw-Hill, 1955. (General)

There's a Nightmare in My Closet. Mercer Mayer, New York: Harper and Row, 1968. (Darkness)

While Suzie Sleeps. Nina Schneider, New York: William R. Scott, Inc., 1948. (Darkness)

Family Areas.

Abby. Jeannette Caines, New York: Harper & Row, 1973. (Adoption)

A Baby Sister for Frances. Russell Hoban, New York: Harper & Row, 1964. (New sibling)

Grandma Didn't Wave Back. Rose Blue, New York: Franklin Watts, Inc., 1972. (Old age)

Luke Was There. Elanor Clymer, New York: Holt, Rinehart, and Winston, 1973. (Foster care)

Me and Mr. Stenner. Evan Hunter, Philadelphia: J.B. Lippincott, 1976. (Stepparent)

My Baby Brother Needs a Friend. Jane B. Moncure, Elgin, Ill.: The Child's World, 1979. (Siblings)

The Pretty House that Found Happiness. Elanor Eisenberg, Austin, Tx.: The Steck Company, 1964. (Adoption)

A Quiet Place. Rose Blue, New York: Franklin Watts, Inc., 1969. (Foster care)

The Temper Tantrum Book. Edna M. Preston, New York: Viking Press, 1969. (Parental demands)

Welcome Child. Pearl S. Buck, New York: John Day, 1963. (Adoption)

Why Couldn't I Be an Only Child Like You, Wigger. Barbara S. Hazen, New York: Atheneum, 1975. (Only child)

Handicaps.

The Door in the Wall. Marguerite DeAngeli, New York: Doubleday and Company, 1949.

Follow My Leader. James B. Garfield, New York: Viking Press, 1958. (Blindness)

He's My Brother. Joe Lasker, New York: Whitman Publishing Company, 1973. (Academic slowness)

MBD: The Family Book about Minimal Brain Dysfunction. Richard Gardner, New York: Aronson, 1973. (Learning and hyperactivity problems)

Spectacles. Ellen Raskin, New York: Antheneum Press, 1968. (Glasses)

The Very Tall Girl. Phyllis Krasilovsky, New York: Doubleday and Company, 1969. (Tallness)

Why Glasses: The Story of Vision. George J. Sands, M.D., Minneapolis: Lerner, 1960.

Medical.

Curious George Goes to the Hospital. Margaret and H.A. Rey, New York: Harper & Row, 1944. (Hospitalization)

The Hospital Scares Me. Paula Z. Hogan, Milwaukee: Raintree, 1980. (Hospitalization)

I Want Mama. Majorie Weinman, New York: Harper & Row, 1974. (Hospitalization of a family member)

The Mind Is a Funny Thing. Barry R. Berkey, M.D., and Velma A. Berkey, Minneapolis: T.S. Dennison, 1973. (Psychiatric help)

Mister Rogers Talks about going to the Doctor. Fred Rogers, New York: Platt & Munk, 1974. (Doctor visits)

What Happens When You Go to the Hospital. Arthur Shay, Chicago: Reilly and Lee. Division of Henry Regnery Comp., 1969. (Hospitalization)

School.

Going to School. Fred Rogers, New York: Platt & Munk, 1974. (Beginning school)

I'd Rather Stay Home. Carol Barkin, Milwaukee: Raintree, 1975. (School avoidance)

Sometimes I Hate School. Carol Barkin, Milwaukee: Raintree, 1975.

The Very Worst Thing. Berthe Amoss, New York: Parent's Magazine Press, 1972. (New school)

Shyness.

Benji. John M. Lexau, New York: Dial Press, 1964.

The Shy Little Girl. Phyllis Krasilovsky, Boston: Houghton-Mifflin Company, 1970.

Note. The preceding list of books was drawn from those books which are commonly available in the elementary schools of the Weber County School District. Schools in other districts may or may not have all of the books listed.

The Clinician as an Educator

Rationale

Braverman (1976) has proposed that a range of mental health workers, ranging from volunteers to psychiatrists, be incorporated into the school system. Their purpose would be to educate all children, to work with emotionally vulnerable children, to support parents, and to carry out research and training in the areas of child mental health and human development. Except in some well-funded demonstration projects, however, this type of scenario is a far cry from reality.

Despite the evidence presented in earlier chapters describing the need for preventive interventions and the solid knowledge base that exists for implementing such interventions, we continue to do next to nothing.

Guerney, Stollack, and Guerney (1971) have suggested that part of the current problem in the provision of preventive services is the adherence of mental health professionals to the medical model with an emphasis on diagnosis and treatment. They urge a shift from case-orientation to programmatic planning. They note that the practicing clinician "following an educational model is one whose work (is centered around) the teaching of personal and interpersonal attitudes and skills which the individual can apply to solve present and future psychological problems and to enhance his satisfaction with life". (p. 277).

The rationale for training educators as guidance leaders is to dispense knowledge-promoting, positive mental health to increasingly larger groups of people. The reasoning for using the clinician in an educative role is nearly identical. The clinician who teaches mental health concepts promotes mental health with a larger population than would normally seek out clinical services. In addition, this group of people may be able to deal with life stresses more appropriately, thus averting the need for professional services at a later time.

Appreciating Existing Skills

Many of the clinician's typical functions encompass skills which are helpful in the teaching situation. The clinician generally communicates meaning well, and is familiar with group dynamics and child development. He/She regularly attempts to teach concepts concerning individual, group or family functioning, and interpersonal relations.

The similarities and differences in role functions between educator and mental health were analyzed by Cohen (1975). Table 1 delineates these variables.

Table 1

(Comparison of Education and Mental Health Professionals on Specific Variables)

	Educator	Mental Health Professional
Goals	To transmit knowledge and skills by educating	To cure or strengthen ego function through strengthening coping ability
Focus	On Groups	On an individual child or educational programs
Techniques	Intellectual	Psychological and social
Communication	Cognitive	Psychological, emotional
Relationship to Child	Traditional, distant	Individualistic, intimate
Time Spent with Child	4-6 hours/day 5 days/week	1 hour/day 1-5 days/week
Administrative Structure	Hierarchial	Independent (occasional supervisory)
Accountability	High	Low
Approach	Preplanned program oriented	Spontaneous child oriented
Social Status	Varied	High
Pay	Varied	High
Source of Professional Satisfaction	Child's productivity: achievement: competence: intellectual power	Child's social/emotional well-being: personality: development: ego strength: self-understanding: self-esteem

Building Teaching Skills

The greatest concern to the clinician in presenting mental health education to students is that of group or classroom management. The students are used to strong structural learning at school. The mental health professional has been taught that heavy structure inhibits free disclosure. The end result is that students respond to the sudden lack of structure by creating chaos. This is, of course, unproductive for the students and frustrating to the clinician.

Clinicians who have successfully taught mental health concepts to students have generally had to employ more structure than they were accustomed to using. Most have utilized systems similar to those used by Loewenstein (1981) in the TOPS program or those used in the DUSO (Dinkmeyer, 1970) kits.

The TOPS program and DUSO both use rule cards which the mental health professional reviews with the group at the beginning of each meeting. Rules include basic courtesy considerations, such as taking turns and keeping arm and legs where they belong. These programs, like many guidance activities, have opening and closing rituals. This allows the child the opportunity to discern when a somewhat different educational milieu exists. The manual accompanying the DUSO kits is an excellent resource and model for clinicians interested in educating students about mental health.

Examples of the Clinician-Educator

TOPS

A prototype program for the clinician-educator has been described in detail by Loewenstein (1981). The Teaching Outreach Prevention School (TOPS) is a school/mental health agency cooperative operating in Dade County, Florida.

A major component of this program is the children's group. The group is led by a therapist in the building. The therapist picks up and returns the children to the classroom. In each session the therapist chooses a well-behaved student to be the student leader. The student leader becomes the first person in the line and also holds up the rule cards at the beginning of each session.

The rule cards emphasize raising hands, since the students are in school. The cards also remind students to keep their hands and feet to themselves, stay in their seats, express their feelings, and let one person speak at a time. Other rule cards are added as they are needed. The emphasis is on authority without it being harsh or punitive.

Loewenstein (1981) has shared some of the activities used in the TOPS groups:

Hot potato: A dry sponge is thrown. A child catches the sponge, makes a feeling statement, and throws the sponge to a new child.

Picture: The children make a picture of a feeling they have recently experienced, then they share the picture and feeling with the group.

Spin-A-Favorite-Feeling: A spinner with different colors on it is used by the children. They each take a turn. Each color on the spinner represents a different favorite feeling: Red = favorite movies; Yellow = pleasant feelings; Green = favorite things to do; White = favorite places.

Circus: In this group building activity, children imitate different circus animals or activities. This also helps gross-motor skills.

Working on Anger: This is a role playing activity where the children are given several strategies for coping in anger-provoking situations.

Sculpting Feelings Game: Real life or hypothetical feeling situations are developed. The children become statues molded to the way the individual child experiences the feeling.

Puppets: Puppetry is often used either as a form of free expression or of more specific expression such as the make-a-family type of play.

Relaxation: Children are taught how to use and practice standard relaxation techniques.

Dial-A-Feeling: Using a dial with happy, sad, mad, angry, scared, and lonely faces on it the child selects the feeling closest to their current feeling and explains the circumstances surrounding the feeling.

Pantomimes: Wordless games are used to show feelings or relevant behaviors.

Entering/Separation Games: Games which clearly denote the opening and closing of each TOPS session help children discriminate between this experience and the other, more cognitively dominated, curriculum presented at school.

Other Projects

Dunlap and Porter (1978) taught a full year mental health promotion course for older students. The course dealt primarily with family issues but also included student identified projects. Students had to complete an individual preventive project of their own design.

Many of the collaborative programs reviewed in the second chapter contain elements or components which utilize the mental health practitioner in an educative role. Several school districts and mental health centers have also established parent centers or parenting programs where clinicians serve as adult educators.

Consultation

History and Rationale

The history of mental health consultation for the aid of children dates back to the infancy of the mental health professions. Freud (1905) records the treatment of Little Hans through the efforts of another adult. Alpert (1976) has also chronicled the history of consultation back to Witmer and the first psychological clinics. As practitioners began to enter the schools, it was clear there would never be enough practitioners to provide services to every student who was in need of help.

Kopplin and Rice (1975) have argued that mental health practitioners need to be aware that they are not primary caregivers for students. It is the teacher and other support staff the students come to first and foremost with their difficulties. If mental health services are to benefit the greatest number of students, then clinicians will have to consult with teachers to enable educators to use the tremendous potential for problem solving that exists.

The recognition that consultation is an integral part of effective mental health promotion was realized with the passage of the Mental Health Services Act by Congress in 1963. A major provision in the law mandated that all mental health centers receiving federal funds should actively provide consultation and education services. The commitment to providing such services has been wavering in recent years. Ironically, the need for such services has never been greater.

Roles and Responsibilities of the School Consultant

Berlin (1977) sees the consultant's role as a helping one in a variety of ways. First, the consultant may be of factual or informational help. Second, he may be of interpretive help. Third, he may be of help in clarifying the integrative role learning may play in dealing with a child's problems. Fourth, the consulting clinician may help the educator preserve his or her own mental health in the face of so many troubled children.

Cohen (1975) has defined a school consultant as, "an individual with a variety of skills who has been invited into a school system to assist the educators to find methods and approaches that will lead to the resolution of difficulties or challenges they face in carrying out their responsibility to educate children" (p. 211).

Dinkmeyer and Caldwell (1970) have characterized the consultation role in terms of the facilitative relationship that must exist. The

necessary conditions for that relationship to exist include:

1. The consultant must be perceived as one who cares and is capable of giving help.

2. Readiness and need undergird the consultant relationship.

3. There must be a relationship of mutual respect, trust, and confidence. The consultant must develop a genuine respect for the teaching profession.

4. The consultation relationship is most helpful and effective when there is an alignment of purposes and goals.

5. The consultant needs to be empathic.

6. After receiving the consultant's opinion, the responsibility as well as the decision for rejecting or using the advice always remains with the one being consulted.

In an almost poetic role statement, J. Murray Lee (cited in Dinkmeyer and Caldwell, 1970) captured the very essence of the school consultant's helping role:

> The consultant should serve as an extra pair of eyes for the teacher to help him see children in situations differently than he would otherwise, an extra pair of hands to help gather more data concerning children, an extra brain to look at this data somewhat differently than the teacher might look at it, and as an extra mouth to occasionally help teachers interpret children to parents; certainly a pair of ears would be extremely helpful to listen to the teacher's side of the story.

Types of Consultation

Consultation has been conceptualized in a number of ways. The classifications used here are related to the focus and recipient of the consultation (Caplan, 1970; Gallessich, 1982).

Case-centered consultation is focused on helping a teacher with the problems of a specific child. This is perhaps the most common type of consultation performed by a clinician in the public sector. The consultant may observe, diagnose, and even treat the child. The teacher is generally given a specific plan for modifying a child's behavior.

Consultee-centered consultation usually focuses upon a specific case also, but the primary goal is to increase the competence of the teacher. The consultant might, for example, help the teacher learn to deal more effectively with hyperactive children.

Program-centered consultation deals with a specific program or project. It may include such things as demonstrations or inservice training. Consultants may also be involved in the areas of program development or evaluation.

Organization-centered consultation is rare for the public sector clinician. It involves utilizing the principles of organizational development (OD) in analyzing and modifying an entire organization. An example of such work is the use of consultants to deal with burn out in a specific social service agency.

Principles and Problems in Consultation

Alpert (1976) holds that the practice of mental health consultation contains four basic assumptions: (a) The consultant can alter the teacher's perception; (b) alteration in teacher perception will affect teacher behavior; (c) alteration in teacher behavior will affect pupil behavior; and (d) teacher learning will be generalized to future cases.

Cohen (1975) described the following principles as basic to consultation in the schools:

1. Consultant activities should be directed toward developing practical procedures useful to each educator and child involved in the process.

2. Consultant approaches should be cognizant of the cultural practices, traditions, and modes of practice accepted in the school and community.

3. Activities should be centered on specific problems or difficulties but should not overlook the long range and broader potential for the solution strategies.

4. Data should be obtained and organized in such a way that it is readily available to provide a continuous feedback of information to help the consultant more effectively target appropriate interventions.

Alpert (1977) posited that the consultant's choice of the target for change would necessarily alter the result of the intervention. Therefore, three guidelines were suggested in selecting a target of

change. First, focus change efforts on the person or subgroup in the interaction who is higher on the organizational chart. Second, focus efforts toward changing several interactions in order to change any interaction. Third, focus change efforts toward those (higher on the organizational chart) who are related to the interaction which is the target of change.

Gallessich (1982) points out that the consultant in a direct service agency, such as a mental health center, often experiences frustration in assuming a consulting role or function. Support for consultation may be weak in such agencies. Norms and rewards are more likely geared to providers of direct services. The direct service provider might also feel some discomfort in leaving the office and placing professional expertise on the line on someone else's turf.

Stages in Consultation

The consultation process, like many processes, proceeds through several stages (Gallessich, 1982; Lippitt & Lippitt, 1978; Altrocchi, 1972). These have been outlined as follows:

1. Preliminary explorations.
2. Negotiating a contract.
3. Entry into the system.
4. Diagnosis.
5. Goal or objective setting.
6. Exploration and selection of alternative intervention strategies.
7. Implementation of intervention strategies.
8. Outcome evaluation.
9. Institutionalizing changes.
10. Termination.

Preliminary explorations are the activities that consultants and consultees go through to determine if the consultant's competencies match the consultee's needs.

Negotiating a contract is where the consultant and consultee formulate, at least in general terms, the ways in which they will work together.

Entry into the system is the point at which the consultant actually begins to do the agreed work. Initial tasks usually involve becoming familiar with the staff and operations of the school or agency and opening up communication.

Diagnosis involves gathering and interpreting data concerning the consultee in sufficient amounts to begin formulating strategies for subsequent work.

Goal or objective setting occurs when the consultant has sufficient information upon which to base judgements. It may be there are no solutions to the problem and consultation might cease at this point. It may be that goals will require further consultation or it may be that goals may be met using internal resources.

Exploration and selection of alternative intervention strategies flow logically from selected goals and the previous diagnostic evaluation. The objective is to find the intervention strategy which best fits with the identified processes of the organization.

Implementation of intervention strategies requires varied amounts of consultant involvement. The consultant role might be that of an active observer or that of implementation director.

Outcome evaluation measures how well established goals have been met. This provides feedback for subsequent decision making.

Institutionalizing changes prevents the loss of gains made during consultation. This process involves making the newly implemented behaviors part of the routine of the organization.

Termination occurs at various points along the process outlined above. Termination may also occur gradually with decreased consultant activity, depending upon several variables.

Gallessich (1982) has devoted several chapters to the stages of consultation. Any professional desiring to increase his or her consultation skills would be well advised to consult with such a comprehensive text.

Ethical Considerations

Haas (1983) outlined nine practical recommendations to help consultants insure the ethical integrity of services:

1. Know who your client is. This includes knowing what impact your consultation will have on whom, and clarifying relationships within the system.

2. Know the law. This means understanding laws that deal with your practice, your consultee, and those with whom your consultee works.

3. Know the code of ethics.

4. Know your own values. You need to be aware of where your sympathies lie, where you will compromise, and what you value in process and outcome.

5. Involve the relevant stakeholders. Since the people most affected by consultation are not always the ones who contract for the service, the stakeholders need advocacy within the process.

6. Be candid. This includes providing informed consent to the consultee. It also includes admitting uncertainty as well as providing honest corrective feedback.

7. Develop a clear contract. It should be accurate, meaningful, and preferably written. (The lack of clarity is the most common complaint teachers level at mental health consultants.)

8. Build re-evaluation into the process.

9. Consult with senior colleagues, sponsors, and peers as needed.

The Special Needs of Preschoolers

Rationale: The Neglected Millions

Day care is rapidly becoming a major industry. As increasingly larger numbers of households are being headed by single parents or working couples, more parents are placing their children in day care settings.

A large share of the home and center based day care is provided in privately owned settings. Much of the government subsidized day care is also contracted through private for-profit settings.

With the exception of such programs as Head Start, few day care establishments provide ancillary mental health services. Thus the increasing number of children from working class home which enter day care are left without recourse as to any form of mental health service, either preventive or remedial.

Monroe (1980) has labeled several areas related to day care service as potentially stressful to the child, the provider, or the parents. Yet, as Hill (1983) has noted, children and children's problems often are not taken seriously when political, social, or educational decisions concerning them are made. Children lack political clout and are in need of advocates.

The developmental impact of prevention in the early years is clear. The molding power of early experiences is a well accepted tenet in the field of child development. Yet relatively little has been done by mental health professionals in the day care arena towards the establishment of primary prevention programs.

The need is present for services. Blai (1981) estimates that approximately 15% of young children may be experiencing some form of mental or emotional problem, usually with a long and gradual onset. Shechtman (1970) notes that young children tend to show a larger number of diffuse symptoms than older children, making identification more difficult.

Often children referred for treatment are not referred based on symptomology, but on several external variables (Johnson & Lobitz, 1974; Lobitz & Johnson, 1975 a & b). The need for well trained, competent mental health consultants and trainers is as clear cut as is the problem.

Barriers and Roadblocks to Intervention

Two constraints have historically operated to minimize the impact of mental health practitioners on the day care/preschool population. The first is a lack of clinical training emphasizing the young child. Secondly, clinicians have often had minimal access to and familiarity with the organizational structure of day care centers.

Training. Greenspan, Nover, and Brunt (1976) cited a review of 97 training programs in child psychiatry. The rather startling results indicated that only one-third of the programs surveyed mentioned a comprehensive study of child development. Only 12 percent of the programs' clinical work with children under the age of five years.

Unfortunately, the other human service fields that deal with children have followed the lead of child psychiatry insofar as training is concerned. This trend will need to be reversed if the helping professions are to provide adequate numbers of consultants with sufficient clinical experience and understanding of child development to meet the current need.

Greenspan et. al. (1976) have outlined several areas of competency which a clinical consultant to day care centers should possess. The consultant needs to have a thorough familiarity with both child psychopathology and the several variations of normality. Clinicians should have a unique understanding of the internal life of the children and an ability to communicate clinical observations into practical suggestions for day care providers. Consultants must also be willing and able to act as advocates for the child. Finally, the mental health professional must be able to observe, assess, and intervene in families and within the organizational structure of the day care institution.

Access and Familiarity with Day Care

Clinicians have had limited access to day care and its organizational structure, due, in large part, to the lack of training previously cited. The lack of sufficient funding of social programs has also impacted the amount of collaboration possible.

Few professionals are willing and able to go out to day care settings and remedy the deficits of their professional training. Until recently there has also been a scarcity of professional literature aimed at upgrading skills of mental health practitioners wishing to expand their knowledge base in this area.

Since the late seventies, funding for outreach programs by mental health agencies has been decreasing. Consultation and education services in mental health centers have diminished. Private day care centers have

not had the financial resources to provide any type of ancillary services, or contract with agencies to provide such services.

Understanding the Day Care Environment

To overcome the lack of training and exposure the clinician has had concerning day care both observation and review of the literature are helpful. Prior to observing a day care program it is helpful to understand the environmental factors that are impinging upon private day care. The author has observed the following:

Funding: A large share of day care provided in the United States is provided by private profit making centers. Many states also channel their subsidized child care through private profit making programs. The nonsubsidized slots are sold at the going rate.

Staffing Patterns: Generally the economic realities of the cost of service versus the fee received have necessitated that the provider maintain the student teacher ratio at the legal maximum. Many centers enroll more than their legal maximum to offset absences and maximize profits. Most of the staff in day care centers are female, with male staff being the exception.

Staff Training: A relatively small number of progressive states or localities have required some form of training and credentialing, such as California. Many states simply require that staff be over 18 and free from tuberculosis. Some centers demand well-trained staffs--many do not.

Wages: Wages are generally much lower than salaries in other educational settings even for the same amount of training. Several for profit centers pay very close to the minimum wage for most of their staff. Few are salaried.

Support Services: Due to the economic realities previously cited few private programs are able to provide any type of support services. Special education, screenings, speech/hearing services, medical, and psychological services are rare.

Regulation: Most of the states have some form of regulatory oversight at the state level. Some municipalities also oversee day care operations. Much of this regulatory action is concerned with building, health, and fire codes and determining if the program is operating within its

licensed enrollment capacity. Attention is rarely given to program or developmental variables.

Greenspan et. al. (1976) found, in extensive consulting with day care providers, that issues concerning children's peer aggression, as well as children being out of control, were the staff issues the authors encountered most frequently. Parker (1977) found preschool teachers had difficulty dealing with the dissonance they felt between their perception of how they ought to feel and how they realistically experienced anger and frustration. Greenspan et. al. (1976) were frequently approached by day care providers who stated parents often asked child development questions which the providers felt ill-prepared to answer.

Types of Community Interventions

Preservice Training

Mental health professionals should become involved in both advocacy for and development of adequate preservice training for preschool and day care staffs. The Child Development Associate (CDA) program provides a nationwide credentialing experience. Included in the CDA training are competencies dealing with behavior and guidance. Mental health professionals would do well to become advisers and consultants for these or similar programs.

Clinicians also need to provide feedback to graduate programs in the helping professions. Graduate schools need to give their trainees opportunity to gain greater exposure and greater clinical skills in working with young children.

Consultation and Inservice Training

The field of consultation has been dealt with previously and need not be repeated in this section. However, the consultant needs to be aware that day care providers may differ in many ways from educators in public elementary schools. These staff members tend to have less undergraduate training, work in a characteristically different setting, and tend to be paid far less than public school educators. The needs and desires, as well as the characteristics of the younger student population, are also different.

Parker (1977) found in consulting with preschools that many teachers found it very difficult to deal with feelings they had toward the children and the guilt they experienced over such feelings. Many myths had to be debunked. Greenspan et. al. (1976) discovered that even among the adequately trained staffs, there was still a lack of information regarding child development issues, especially in the areas of social and emotional growth.

Inservice training allows the opportunity for staffs already providing services to enhance their skills and remedy any deficits they might have in providing child care. Common inservice themes include both the areas of child development and of working with parents.

Topics around working with parents have included conferencing skills, parent involvement, orientation services, discussing expectations, and educational counseling of parents. Child development issues often center around individual and group management skills, but can include such topics as environmental considerations at the center, appropriate toys, and curriculum concerns.

Interventions into the Family

Friedman and Friedman (1982) have suggested that day care provides a unique opportunity for expanding contacts with families that might not directly seek mental health services. They note that day care workers are often aware of sudden changes in a child's family constellation as well as marked changes in the child's behavior which may signal change in family functioning.

The authors suggest that the clinician adopt a liaison role to assess the child's dysfunction in the context of the family. The therapist should facilitate and coordinate interagency support networks, as well as build on the strengths within the family system, thus aiding in adequate family functioning. Central to this model is active utilization of the day care provider, who has regular contact with families, and the building of trust through the use of nonproblematic contacts.

Even day care centers which do not have a formal collaborative arrangement with mental health practitioners can become more effective agents of change through the judicious use of community resources. By becoming acquainted with the services and staffs of community agencies the day care center becomes an informational and referral agency in its own right.

Therapeutic Preschool Approaches

Programs which recognize and utilize therapeutic principles in their service patterns are included in this category. They may vary from a center attempting to reduce stressful elements in its environment to a residential treatment program for preschoolers.

Monroe (1980) has outlined a six point program for reducing the situational stress on children in day care. It includes the following:

1. Supporting the Family
   - -Show concern
   - -Make home visits
   - -Avoid judgements
   - -Be alert to parent's needs
   - -Model appropriate interactions
   - -Hold conferences

2. Communicating
   -Greet each child as he or she arrives
   -Plan for consistency with other caregivers
   -Relay parent's instruction to other caregivers
   -Relay the child's special needs to other caregivers
   -Tell each child "good-bye"

3. Consider the Needs of Individuals as well as Groups
   -Know each child's family (who they talk about)
   -Keep groups small
   -Use learning centers
   -Plan equipment and room arrangement
   -Keep flexible schedules
   -Recognize success

4. Setting and Enforcing Limits
   -Establish reasonable limits
   -Be consistent
   -Give choices when appropriate
   -Give positive directions
   -Disapprove of the act and not of the child
   -Use your natural voice
   -Keep your message simple
   -Watch your body language

5. Assessing the Needs of Children
   -Take descriptive notes
   -Be alert to patterns of skill development
   -Pinpoint specific times when a child is disruptive
   -Have professional conferences

6. Organizing the Physical Environment
   -Be prepared
   -Control the noise level
   -Keep things near where they are used
   -Provide uncluttered traffic lanes around, not through, activities

Greenspan et. al. (1976) describe four ways early child care settings can foster emotional growth. First, perceive accurately what the child is saying. Second, understand with empathy what the child is experiencing. Third, respond in a temporally effective way to the child's communication. Finally, respond flexibly and differentially to what the child is communicating. Jennings (1982) has provided excellent guidelines to enhance this type of therapeutic interaction with children.

Tasch (1971) contends that the therapeutic preschool must contain both preventive as well as prescriptive services. The main thrusts of the preventive program include the academic program, teacher behavior, and parent education.

Tasch also notes that the therapeutic or prescriptive component of such programs must be cognizant of several aspects of dealing with young children. Diagnostically, the younger the child, the more difficult it is to make an adequate evaluation. Parents are an essential part of the clinical picture and are necessary to help the clinician sort through the multiplicity of possible causes for behavior.

Team approaches are invaluable for both diagnosis and treatment in the day care setting since teams provide for a pooling of interdisciplinary strengths (Wax, 1971; Tasch, 1971). Inclusion of the teaching staff is essential in the team approach since Tasch (1971) contends that treatment and management procedures are more effective when carried out in the social setting of the preschool classroom as opposed to the therapist's office.

Conclusion

The challenge for the prevention oriented clinician is clear and convincing. Within the preschool awaits what is perhaps the most appropriate audience to target prevention toward - the neglected millions.

Making Prevention Work

The Reality of Funding

The last several years have seen major shifts in funding priorities at all levels of government. The emphasis has turned away from social programs in general and from prevention programs in particular.

Legg (1980) has noted that mental health agencies, faced with reduced budgets as well as current serious emotional problems in their clientele, have delayed implementation of primary prevention programs. The reality is that current problems have significantly drained the mental health dollar. Legg holds that this dilemma has resulted in the decision to give only lip service to the area of preventive mental health.

Social service administrators have long understood that primary prevention is cost effective in terms of units expended for units of gain. The difficulty has arisen because preventive programs have not been seen as revenue producing.

There are several areas in which prevention programs could be seen as revenue producing. These include increasing referrals through collaboration, expanding the use of collateral therapy, grantsmanship, and exploration of third party reimbursement for collaborative services.

Pressman (1979), in describing methods practitioners use to increase referrals, described several strategies similar to the collaborative efforts outlined earlier in this guidebook. Although clinician-led prevention programs may do much to reduce new incidence of mental disorders, they also provide an avenue of referral for the already troubled child. Thus the agency which employs community interventions invariably increases referrals to the agency.

The second area of revenue production that mental health agencies should explore is the creative use of collateral therapy. Many insurance carriers and welfare plans allow for the use of collateral contacts with significant people in the client's life. Clinicians fail to realize that many concepts dealt with in a one-on-one collateral contact would be beneficial to a larger audience. Instead of discussing Johnny's problem with his teacher, why not also involve the other teachers in the grade and the principal. The problems which Johnny has will be similar to problems other children will have at some later date. Inservice training can be centered around one child's case.

A third area for exploration is seeking grants to fund preventive programs. There are still government agencies, corporations, and foundations that will fund or partially subsidize innovative programs in

several areas. An example is the recent trend in some states to provide funds for alcoholism prevention programs aimed at young children.

The final area, which has received very little public attention, is the area of obtaining third party reimbursement for collaborative services. Current laws prohibit reimbursement for services schools are legally mandated to provide. Several collaborative services, such as a mental health unit located in a school, go above and beyond the legally mandated school services. These services should, therefore, be eligible for reimbursement from third parties, such as insurance carriers and government agencies.

Evaluation of Prevention Programs

Beyond funding, the second major hurdle prevention programs face is evaluation. By definition prevention results in the nonoccurrence of certain observable behaviors or symptoms. This has made evaluation of prevention less scientific and more difficult. It has not made evaluation impossible.

The outline below was excerpted from Reinherz (1981). It identifies both general principles and specific technical considerations necessary to properly evaluate prevention programs.

General Principles of Evaluation

I. Specifications of objectives and outcomes.
   A. Objectives pointing to future outcomes should be realistic and relevant.
   B. At times goals can only be measured indirectly.
      1. Opportunities for longitudinal follow-up are limited.
      2. Long term goals may be estimated by achievement of short term goals that previous research has linked to the long term goal.
   C. Caution needs to be taken not to infuse investigator values into the selection of objectives for evaluation.

II. Definition of the preventive intervention.
   A. Newer interventions may not be tested or documented.
   B. Older interventions, e.g. consultation, may have variations in form or purpose.
   C. It is critical to specify the independent variable.

III. Specification of target groups.
   A. Specific populations.
      1. Groups at risk.
      2. Total population.
      3. Helping professionals.
      4. Policy makers.
   B. Non-target groups serendipitously affected by interventions should be noted and allowed for in the design.

IV. Long-term and short-term follow-up.
  A. Prevention is future oriented.
  B. Long term impact needs to be assessed.
  C. Difficulties in long-term follow-up.
    1. Attrition and population mobility.
    2. Representativeness of the population.

Technical Considerations in Evaluation

I. Experimental designs.
  A. Many are convinced that experimental evaluative designs are the most valid types of designs.
  B. Options of randomized controls does not occur frequently in the area of human services.

II. Formative and process designs.
  A. Suitable for early stages of development.
  B. Provides careful documentation of the new intervention.
    1. Exact service being delivered.
    2. Identification of exactly who receives the service or program.

III. Summative designs.
  A. Appropriate for well established programs.
  B. Experimental designs may be attempted or approximated.
  C. Quasi-experimental designs.
    1. Control series designs.
    2. Comparison groups from other geographic areas.
  D. Single subject or single system designs.
  E. Combinations of designs to deal with the complexity of measurement.

IV. Measures representing desired outcomes.
  A. Must fit objectives as precisely as possible.
  B. There must be appropriate measures for each outcome.
  C. Multiple measures should be used for all important areas.

V. Types and sources of information.
  A. Types of information.
    1. Attitudes.
    2. Beliefs.
    3. Behaviors.
    4. Performance.
  B. Sources of information.
    1. Clients.
    2. Schools.

3. Agencies.
4. Professional judgement.
5. Media reports.
6. Official records.

C. Convincing measures are usually behaviorally grounded.

VI. Consumer self-reports and professional judgements.
A. Often the only measures available.
B. Clinical judgement is often used in mental health studies.
1. Measure status of mental health, adjustment, and coping.
2. Difficult to standardize to ensure reliability.
3. Expensive form of data to gather.

This brief outline is not intended to be a comprehensive text on evaluation. The reader would do well to consult the relevant literature (Munoz, 1976).

Expanding the Umbrella

It should be evident at this point that prevention is both necessary and possible. The literature has shown that the practice of prevention is no longer in its infancy. There is a solid base of research and practice on which to build.

Due to political and economic realities it becomes incumbent of every mental health professional to expand his or her practice to incorporate mental health promotion services. This guidebook has outlined several methods to aid in that expansion.

Current practice can be easily and immediately enriched by additional consultation and collateral contacts with expanded audiences. Public education and preschool contacts can be established and result in increased referrals to the agency. As competencies grow, additional collaborative and community interventions become possible.

The Promise of Prevention

Prevention will probably never be able to eliminate every impending case of mental or emotional disorder. It will result in a larger adult population able to adequately cope with a rapid, impersonal, technological society. The value of prevention as a form of effective child guidance becomes clearer as we realize the world we mold for our children is perhaps the greatest gift we have to give.

REFERENCES

Alpert, J.L. Conceptual bases of mental health consultation in the schools. Professional Psychology, 1976, 7, 619-626.

Alpert, J.L. Some guidelines for school consultants. Journal of School Psychology, 1977, 15, 308-319.

Altrocchi, J. Mental health consultation. In S.E. Goldman C. Eisdorfer (Eds.) Handbook of community mental health. New York: Appleton-Century-Crofts, 1972.

Barksdale, A.W. A mobile program to provide mental health services to students of an inner-city school and their families. Doctoral practicum, Nova University, 1979. (ERIC Document Reproduction Service No. ED 186 810).

Barr, W. & Delfava, C. Public school and community mental health inter-agency cooperation for treatment of the child with special educational needs. Tacoma, Wash.: Child Study and Guidance Clinic, 1980. (ERIC Document Reproduction Service No. ED 201 077).

Berlin, I.N. Preventive aspects of mental health consultation to schools. In J. Meyers, R. Martin, & I. Hyman (eds.) School consultation: Readings about preventive techniques for pupil personnel workers. Springfield, IL.: Charles C. Thomas, 1977.

Blai, B. Jr. Mentally ill children. Gradyville, Pennsylvania, 1981. (Eric Document Reproduction Service No. ED 203 258).

Braverman, J. The school system as the vehicle of preventive psychiatry. Canadian Journal of Public Health, 1976, 67, 61-63.

Buchholz, E.S. The proper study for children: Children and their feelings. Psychology in the Schools, 1974, 11, 10-15.

Caplan, G. Theory and practice of mental health consultation. New York: Basic Books, 1970.

Caplan, G. & Grunebaum, H. Perspectives on primary prevention: A review. Archives of General Psychiatry, 1967, 17, 331-346.

Cohen, R. Co-professional collaborative school consultation model. In C.A. Parker (ed.) Psychological consultation: Helping teachers meet special needs. Minneapolis: University of Minnesota, 1975.

Couchman, R. The unrealized resource: Impact of the schools on children's mental health. The School Guidance Worker, 1980, 35, 12-18.

D'Augelli, A.R., Danish, S.J., Hauer, A.L., & Conter, J.J. Helping skills: A basic training program (2nd ed.). New York: Human Sciences Press, 1980.

Dinkmeyer, D., & Caldwell, E. Developmental counseling and guidance: A comprehensive school approach. New York: McGraw-Hill, 1970.

Dunlap, D.A., & Porter, D. The school consultant as teacher: Preventive mental health curriculum in a rural public high school. Paper presented at the annual meeting of the American Orthopsychiatric Association, San Francisco, March, 1978. (ERIC Document Reproduction Service No. ED 160 949).

Dunn, F.M., & Howell, R.J. Relaxation training and its relationship to hyperactivity in boys. Journal of Clinical Psychology, 1982, 38, 92-100.

Freud, S. Analysis of a phobia in a five year old boy. In The complete psychological works of Sigmund Freud, 1909, Vol. 10. London: The Hogarth Press, 1955, 3-149.

Friedman, D.H., & Friedman, S. Day care as a setting for intervention in family systems. Social Casework, 1982, 63, 291-295.

Gallessich, J. The profession and practice of consultation. San Francisco: Jossey-Bass, 1982.

Georgia comprehensive guidance series. Program planning guide. Georgia State Department of Education: Atlanta, Ga., 1981. (ERIC Document Reproduction Service No. ED 222 784).

Gilman, S. Preventative mental health programs and school systems: A review of the literature. Ottawa, Ontario, Canada: Canadian Mental Health Association, 1981. (ERIC Document Reproduction Service No. 214 073).

Glasser, W. Schools without failure. New York: Harper & Row, 1969.

Goldston, S.E. Emerging primary prevention programs: 1978. Paper presented at the annual meeting of the American Psychological Association, Toronto, Ontario, Canada, August, 1978. (ERIC Document Reproduction Service No. ED 167 880).

Greenspan, S.I., Nover, R.A., & Brunt, C.H. The child psychiatrist and day care. Journal of the American Academy of Child Psychiatry, 1976, 15, 108-130.

Guerney, B., Jr., Stollack, G., & Guerney, L. The practicing psychologist as educator--An alternative to the medical practitioner model. Professional Psychology, 1971, 2, 276-282.

Haas, L.J. Ethical issues in consultation. In P.A. Keller and L.G. Ritt (Eds.) Innovations in clinical practice: A sourcebook, Vol. II. Sarasota, Fl.: Professional Resource Exchange, Inc., 1983.

Hauck, R. Primary guidance activities. Grove City, Oh.: South-Western City School District, 1978. (ERIC Document Reproduction Service No. ED 017 121).

Hill, B.M. Development and implementation of a psychodiagnostic assessment program for young children in a mental health center. Unpublished doctoral practicum, Nova University, 1983.

Holliday, B. Collaboration between child mental health services and public schools. Paper presented at the annual convention of the American Psychological Association. New York, September, 1979. (ERIC Document Reproduction Service No. ED 182 662).

Jennings, R.L. Basic considerations in interviewing children. Des Moines, Iowa: Iowa State Department of Public Instruction, 1982. (ERIC Document Reproduction Service No. ED 230 884).

Johnson, S.M., & Lobitz, G.K. The personal and marital adjustment of parents as related to observed child deviance and parenting behavior. Journal of Abnormal Child Psychology, 1974, 2, 193-207.

Kellam, S.G., Brown, C.H., Rubin, B.R., & Ensminger, M.E. Paths leading to teenage psychiatric symptoms and substance use: Developmental epidemiological studies in Woodlawn. Chicago, Ill.: University of Chicago, 1982. (ERIC Document Reproduction Service No. ED 215 787).

Koeppen, A.S. Relaxation training for children. Elementary School Guidance & Counseling, 1974, 9, 14-21.

Kopplin, D.A., & Rice, L.C. Consulting with faculty: necessary and possible. Personnel and Guidance Journal, 1975, 53, 367-372.

Koren, E.T. Flexible guidance in the elementary school: Tested techniques for a stress-free classroom. New York: Center for Applied Research in Education, 1974.

Legg, J. The elementary school mental health project: A school program aimed at the promotion of mental health in young children. Ottawa, Ontario, Canada: Ottawa Board of Education, 1980. (ERIC Document Reproduction Service No. ED 210 115).

Lippitt, G., & Lippitt, R. The consulting process in action. San Diego, Calif.: University Associates, 1978.

Lobitz, G.K., & Johnson, S.M. Normal versus deviant children: a multimethod comparison. Journal of Abnormal Child Psychology, 1975, 3, 353-374.

Lobitz, G.K., & Johnson, S.M. Parental manipulation of the behavior of normal and deviant children. Child Development, 1975, 46, 719-726.

Loewenstein, A. Children's group manual. TOPS program: A school/mental health cooperative. Miami: Dade County Public Schools, 1981. (ERIC Document Reproduction Service No. ED 215 513).

Long, B.E. A model for elementary school behavioral science as an agent of primary prevention. American Psychologist, 1970, 25, 571-574.

Loveless, S.C. Oklahoma Child Development Associate curriculum: Behavior and guidance. (Rev. ed.) Midwest City, Ok.: Oscar Rose Junior College, 1981. (ERIC Document Reproduction Service No. ED 208 996).

Mansheim, P. The evaluation of early warning signs of emotional disturbance in childhood. Education, 1982, 102, 330-334.

Monroe, M. Families, day care, and stress. Paper presented at the annual meeting of the National Association for the Education of Young Children, San Francisco, November, 1980. (ERIC Document Reproduction Service No. ED 206 383).

Munoz, R. The primary prevention of psychological problems: A review of the literature. Community Mental Health Review, 1976, 1, 1-15.

Muro, J.J., & Dinkmeyer, D.C. Counseling in the elementary and middle schools: A pragmatic approach. Wm. C. Brown Company Publishers, Debuque, IO., 1977.

Parker, B. Some observations on psychiatric consultation with nursery school teachers. In J. Meyers, R. Martin, & I. Hyman (eds.) School consultation: Readings about preventive techniques for pupil personnel workers. Springfield, IL.: Charles C. Thomas, 1977.

Pressman, R.M. Private practice: A handbook for the independent mental health practitioner. New York: Gardner Press, 1979.

Redfering, D.L., & Bowman, M.J. Effects of a meditative-relaxation exercise on non-attending behaviors of behaviorally disturbed children. Journal of Clinical Child Psychology, 1981, 10, 126-127.

Reinherz, H. Evaluating programs of primary prevention: How can we know if they make a difference? In M. Nobel (ed.) Primary prevention in mental health and social work. New York: Council on Social Work Education, 1981. (ERIC Document Reproduction Service No. ED 214 423).

Rossman, H.M., & Kahnweiler, J.B. Relaxation training with intermediate grade students. Elementary School Guidance and Counseling, 1977, 11, 259-266.

Rutter, M. Fifteen thousand hours: Secondary schools and their effects on children. London: Open Books, 1979.

Shechtman, A. Age patterns in children's psychiatric symptoms. Child Development, 1970, 41, 683-693.

Tasch, R.J. Guidance at the preschool level. In G.D. Mills (ed.) Elementary school guidance and counseling: An introduction through essays and commentaries. New York: Random House, 1971.

Tauss, V. The teacher as counselor in school systems in transition. Bayside, N.Y.: Queensborough Community College, CUNY, 1980. (ERIC Document Reproduction Service No. ED 201 918).

Wax, J. A mental health preschool program: Helping preschoolers with emotional and behavioral problems. Columbia, Missouri: Mid-Missouri Mental Health Center, 1971. (ERIC Document Reproduction Service No. ED 192 933).

Wolpe, J. Psychotherapy by reciprocal inhibition. Stanford, CA.: Stanford University Press, 1958.

REFERENCE NOTES

1. Cragun, K. D. Personal communication, September, 1983.

2. Fielding, S. Personal communication, September, 1983.

3. Judkins, S. K. Personal communication, June, 1982.

4. Parker, K. Personal communication, February, 1983.

5. Vaterlaus, R. K. Personal communication, May, 1983.

BIBLIOGRAPHY

Alpert, J. L. Conceptual bases of mental health consultation in the schools. Professional Psychology, 1976, 7, 619-626.

Alpert, J. L. Some guidelines for school consultants. Journal of School Psychology, 1977, 15, 308-319.

Alschuler, A. S., Carl, J., Leslie, R., Schweiger, I., & Uustal, D. (Eds.), Teacher burnout. Analysis and action series. Washington, D. C.: National Education Association, 1980. (ERIC Document Reproduction Service No. ED 201 640)

Altrocchi, J. Mental health consultation. In S. E. Goldman C. Eisdorfer (Eds.), Handbook of community mental health. New York: Appleton-Century-Crofts, 1972.

Anderson, R. F. Using guided fantasy with children. Elementary School Guidance & Counseling, 1980, 15, 39-47.

Barksdale, A. W. A mobile program to provide mental health services to students of an inner-city school and their families. Doctoral practicum, Nova University, 1979. (ERIC Document Reproduction Service No. ED 186 810)

Barr, W., & Delfava, C. Public school and community mental health interagency cooperation for treatment of the child with special educational needs. Tacoma, Wash.: Child Study and Guidance Clinic, 1980. (ERIC Document Reproduction Service No. ED 201 077)

Berg-Cross, G., & Berg-Cross, L. Bibliotherapy for young children. Journal of Clinical Child Psychology, 1976, 5, 35-38.

Berlin, I. N. Preventive aspects of mental health consultation to schools. In J. Meyers, R. Martin, & I. Hyman (Eds.), School consultation: Readings about preventive techniques for pupil personnel workers. Springfield, IL.: Charles C. Thomas, 1977.

Blai, B. Jr. Mentally ill children. Gradyville, Pennsylvania, 1981. (ERIC Document Reproduction Service No. ED 203 258)

Bolman, W. M., & Westman, J. C. Prevention of mental disorder: An overview. American Journal of Psychiatry, 1967, 123, 1058-1068.

Borg, W. R., & Gall, M. D. Educational research: An introduction (3rd ed.). New York: Longman, Inc., 1979.

Braverman, J. The school system as the vehicle of preventive psychiatry. Canadian Journal of Public Health, 1976, 67, 61-63.

Brett, A. The influence of affective education on the cognitive performance of kindergarten children. Child Study Journal, 1978, 8, 165-174.

Broskowski, A., & Baker, F. Professional, organizational, and social barriers to primary prevention. American Journal of Orthopsychiatry, 1974, 44, 707-719.

Buchholz, E. S. The proper study for children: Children and their feelings. Psychology in the Schools, 1974, 11, 10-15.

Cantor, C. L., & Helfat, L. Training for affective education: A model for change in the schools. Journal of Clinical Child Psychology, 1976, 5, 5-8.

Caplan, G. Theory and practice of mental health consultation. New York: Basic Books, 1970.

Caplan, G. An approach to primary prevention in child psychiatry. Canadian Journal of Psychiatry, 1980, 25, 671-682.

Caplan, G., & Grunebaum, H. Perspectives on primary prevention: A review. Archives of General Psychiatry, 1967, 17, 331-346.

Carkhuff, R. R. The art of problem solving: A guide for developing problem-solving skills for parents, teachers, counselors, and administrators. Amherst, N. J.: Human Resource Development Press, 1973.

Carkhuff, R. R. The art of helping: An introduction to life skills. Amherst, N. J.: Human Resource Development Press, 1974.

Chesler, M., & Fox, R. Role playing methods in the classroom. Chicago, IL.: Science Research Associates, 1966.

Cline, V. How to make your child a winner: Ten keys to rearing successful children. New York: Walker Publishing Company, 1980.

Cohen, R. Co-professional collaborative school consultation model. In C. A. Parker (Ed.), Psychological consultation: Helping teachers meet special needs. Minneapolis: University of Minnesota, 1975.

Conye, R. K. Primary prevention: A new direction for counseling psychologists. Paper presented at the annual convention of the American Psychological Association. Montreal, Quebec, Canada, September, 1980.

Couchman, R. The unrealized resource: Impact of the schools on children's mental health. The School Guidance Worker, 1980, 35, 12-18.

Cullari, S., & Redmon, W. K. Obstacles affecting the development of behavioral prevention. Paper presented at the annual convention of the Association for Behavior Analysis, Dearborn, Mich., June, 1979.

D'Augelli, A. R., Danish, S. J., Hauer, A. L., & Conter, J. J. Helping skills: A basic training program (2nd ed.). New York: Human Sciences Press, 1980.

Dinkmeyer, D., & Caldwell, E. Developmental counseling and guidance: A comprehensive school approach. New York: McGraw-Hill, 1970.

Dunlap, D. A., & Porter, D. The school consultant as teacher: Preventive mental health curriculum in a rural public high school. Paper presented at the annual meeting of the American Orthopsychiatric Association, San Francisco, March, 1978. (ERIC Document Reproduction Service No. ED 160 949)

Dunn, F. M., & Howell, R. J. Relaxation training and its relationship to hyperactivity in boys. Journal of Clinical Psychology, 1982, 38, 92-100.

Ehly, S., & Eliason, M. Consultation: A collection of references from education and psychology. Iowa: University of Iowa, 1980. (ERIC Document Reproduction Service No. ED 190 941)

Ferguson, D. G., Gibbs, H. M., & Liddle, G. P. Models for pupil services in elementary schools. College Park, MD.: University of Maryland, 1969. (ERIC Document Reproduction Service No. ED 040 504)

Freud, S. Analysis of a phobia in a five year old boy. In The complete psychological works of Sigmund Freud, 1909, Vol. 10. London: The Hogarth Press, 1955, 3-149.

Friedman, D. H., & Friedman, S. Day care as a setting for intervention in family systems. Social Casework, 1982, 291-295.

Gallessich, J. The profession and practice of consultation. San Francisco: Jossey-Bass, 1982.

Georgia comprehensive guidance series. Program planning guide. Georgia State Department of Education: Atlanta, Ga., 1981. (ERIC Document Reproduction Service No. ED 222 784)

Gilman, S. Preventative mental health programs and school systems: A review of the literature. Ottawa, Ontario, Canada: Canadian Mental Health Association, 1981. (ERIC Document Reproduction Service No. ED 214 073)

Giltzow, S. D. Magic Circle: Effect of the Human Development Program on pupil and teacher self-concept. Unpublished doctoral dissertation, Brigham Young University, 1981.

Glasser, W. Schools without failure. New York: Harper & Row, 1969.

Goldston, S. E. Emerging primary prevention programs: 1978. Paper presented at the annual meeting of the American Psychological Association, Toronto, Ontario, Canada, August, 1978. (ERIC Document Reproduction Service No. ED 167 880)

Greenspan, S. I., Nover, R. A., & Brunt, C. H. The child psychiatrist and day care. Journal of the American Academy of Child Psychiatry, 1976, 15, 108-130.

Guerney, B., Jr., Stollack, G., & Guerney, L. The practicing psychologist as educator--An alternative to the medical practitioner model. Professional Psychology, 1971, 2, 276-282.

Haas, L. J. Ethical issues in consultation. In P. A. Keller and L. G. Ritt (Eds.), Innovations in clinical practice: A sourcebook, Vol. II. Sarasota, Fl.: Professional Resource Exchange, Inc., 1983.

Hauck, R. Primary guidance activities. Grove City, Oh.: South-Western City School District, 1978. (ERIC Document Reproduction Service No. ED 213 490)

Hayes, W. A., Jackson, J., & Milbrath, C. The child and family mental health evaluation project. Summary of fall 1980 data analysis. San Francisco: Urban Institute for Human Services, 1981. (ERIC Document Reproduction Service No. ED 213 490)

Henderson, T. A review of the literature on affective education. Contemporary Education, 1974, 44, 93-99.

Hill, B. M. Development and implementation of a psychodiagnostic assessment program for young children in a mental health center. Unpublished doctoral practicum, Nova University, 1983.

Holliday, B. Collaboration between child mental health services and public schools. Paper presented at the annual convention of the American Psychological Association. New York, September, 1979. (ERIC Document Reproduction Service No. ED 182 662)

Jennings, R. L. Basic considerations in interviewing children. Des Moines, Iowa: Iowa State Department of Public Instruction, 1982. (ERIC Document Reproduction Service No. ED 230 884)

Jewett, C. L. Helping children cope with separation and loss. Harvard, Mass.: The Harvard Common Press, 1982. (ERIC Document Reproduction Service No. ED 219 145)

Johnson, S. M., & Lobitz, G. K. The Personal and Marital Adjustment of Parents as Related to Observed Child Deviance and Parenting Behavior. Journal of Abnormal Child Psychology, 1974, 2, 193-207.

Kaczkowski, H., & Patterson, C. H. Counseling and Psychology in elementary schools. Springfield, IL: Charles C. Thomas, 1975.

Keat, D. B. Fundamentals of child counseling. Boston: Houghton Mifflin, 1974.

Keat, D. B. Multimodal therapy with children. New York: Permagon Press, 1979.

Kellam, S. G., Brown, C. H., Rubin, B. R., & Ensminger, M. E. Paths leading to teenage psychiatric symptoms and substance use: Developmental epidemiological studies in Woodlawn. Chicago, IL.: University of Chicago, 1982. (ERIC Document Reproduction Service No. ED 215 787)

Kelly, J. G. The quest for valid preventive interventions. In American Psychological Association's Issues in community psychology and preventive mental health. New York: Behavioral Publications, 1971.

Koeppen, A. S. Relaxation training for children. Elementary School Guidance and Counseling, 1974, 9, 14-21.

Koolen, M. F. Evaluation summary for the Cooperative Mental Health Service. Douglas County, Neb.: School District #66, 1968. (ERIC Document Reproduction Service No. ED 032 550)

Kopplin, D. A., & Rice, L. C. Consulting with faculty: Necessary and possible. Personnel and Guidance Journal, 1975, 53, 367-372.

Koren, E. T. Flexible guidance in the elementary school: Tested techniques for a stress-free classroom. New York: Center for Applied Research in Education, 1974.

Krumboltz, J. D., & Krumboltz, H. B. Changing Children's Behavior. Englewood Cliffs, N. J.: Prentice-Hall, 1972.

Legg, J. The elementary school mental health project: A school program aimed at the promotion of mental health in young children. Ottawa, Ontario, Canada: Ottawa Board of Education, 1980. (ERIC Document Reproduction Service No. ED 210 115)

Lemle, R. Primary prevention of psychological disorders in elementary and intermediate schools. Journal of Clinical Child Psychology, 1976, 5, 26-32.

Levine, E. Affective education: Lessons in ego development. Psychology in the Schools, 1973, 10, 147-150.

Lippitt, G., & Lippitt, R. The consulting process in action. San Diego, Calif.: University Associates, 1978.

Lobitz, G. K., & Johnson, S. M. Normal versus deviant children: A multimethod comparison. Journal of Abnormal Child Psychology, 1975, 3, 353-374.

Lobitz, G. K., & Johnson, S. M. Parental manipulation of the behavior of normal and deviant children. Child Development, 1975, 46, 719-726.

Loewenstein, A. Children's group manual: TOPS program: A school/mental health cooperative. Miami: Dade County Public Schools, 1981. (ERIC Document Reproduction Service No. ED 215 513)

Long, B. E. A model for elementary school behavioral science as an agent of primary prevention. American Psychologist, 1970, 25, 571-574.

Loveless, S. C. Oklahoma Child Development Associate curriculum: Behavior and guidance (Rev. ed.). Midwest City, OK.: Oscar Rose Junior College, 1981. (ERIC Document Reproduction Service No. ED 208 996)

Lupin, M., Braud, L. W., Braud, W., & Duer, W. F. Children, parents and relaxation tapes. Academic Therapy, 1976, 12, 105-112.

Mansheim, P. The evaluation of early warning signs of emotional disturbance in childhood. Education, 1982, 102, 330-334.

Matthews, D. B., & Quinn, J. L. Dealing with stress: A major component of a parent education program. Paper presented at the annual convention of the American Personnel and Guidance Association, St. Louis, April, 1981. (ERIC Document Reproduction Service No. ED 208 284)

McBeath, M. Consulting with teachers in two areas: Grief and mourning: Relaxation techniques. Personnel and Guidance Journal, 1980, 58, 473-476.

McWilliams, S. A., & Finkel, N. J. High schools students as mental health aides in the elementary school setting. Journal of Consulting & Clinical Psychology, 1973, 40, 39-42.

Melcer, D. Family therapy and the school system. Paper presented at the annual meeting of the National Council on Family Relations, Milwaukee, WI, October, 1981. (ERIC Document Reproduction Service No. ED 217 354)

Mestler, J. E. Behavioral changes of elementary students involved in the Human Development Program: "Magic Circle". Journal of Clinical Child Psychology, 1976, 5, 18-20.

Miller, G. A. Psychology as a means of promoting human welfare. American Psychologist, 1969, 24, 1063-1075.

Monnroe, V., Snell, V., & Gunderson, M. Kindergarten activities guide. Georgia comprehensive guidance series. Atlanta, Ga.: Georgia State Department of Education, 1981. (ERIC Document Reproduction Service No. ED 222 787)

Monroe, M. Families, day care, and stress. Paper presented at the annual meeting of the National Association for the Education of Young Children, San Francisco, November, 1980. (ERIC Document Reproduction Service No. ED 206 383)

Moracco, J. Field observation and recording procedures. Elementary School Guidance and Counseling, 1977, 12, 127-132.

Morgan, S. R. Bibliotherapy: A broader concept. Journal of Clinical Child Psychology, 1976, 5, 39-42.

Moskowitz, J. M., Schaps, E., & Malvin, J. A process evaluation of a Magic Circle primary prevention program. Napa, Ca.: Pacific Institute for Research and Evaluation, 1980. (ERIC Document Reproduction Service No. ED 202 905)

Munoz, R. The primary prevention of psychological problems: A review of the literature. Community Mental Health Review, 1976, 1, 1-15.

Muro, J. J., & Dinkmeyer, D. C. Counseling in the elementary and middle schools: A pragmatic approach. Wm. C. Brown Company Publishers, Dubuque, IO., 1977.

New Jersey State Department of Education, Working with community resources: A guide for child care centers. Trenton, N. J.: New Jersey State Department of Education, 1979. (ERIC Document Reproduction Service No. ED 219 148)

Nixon, G. Systems approach to pediatric consultation. Journal of Clinical Child Psychology, 1975, 4. 33-35.

Nobel, M. (Ed.). Primary prevention in mental health and social work: A sourcebook of curriculum and teaching materials. New York: Council on Social Work Education, 1981. (ERIC Document Reproduction Service No. ED 214 423)

Parker, B. Some observations on psychiatric consultation with nursery school teachers. In J. Meyers, R. Martin, & I. Hyman (Eds.), School consultation: Readings about preventive techniques for pupil personnel workers. Springfield, IL.: Charles C. Thomas, 1977.

Peters, H. J., Shertzer, B., & VanHoose, W. Guidance in elementary schools. Chicago: RandMcNally & Company, 1965.

Phinney, J., Barry, S., Dittman, L., & Huebner, R. Hairy scary. Children's fears: Face them. Student Guide--Footsteps. Report 16. Silver Spring, MD.: Applied Management Sciences, Inc., 1979. (ERIC Document Reproduction Service No. ED 169 942)

Pressman, R. M. Private practice: A handbook for the independent mental health practitioner. New York: Gardner Press, 1979.

Proeger, C., & Myrick, R. D. Teaching children to relax. Ft. Meyers, Fl.: Florida Educational and Development Council, Inc., 1980. (ERIC Document Reproduction Service No. ED 206 393)

Read, K. The nursery school (A human relationships laboratory). (4th ed.). Philadelphia: Saunders, 1966.

Redfering, D. L., & Bowman, M. J. Effects of a meditative-relaxation exercise on non-attending behaviors of behaviorally disturbed children. Journal of Clinical Child Psychology, 1981, 10, 126-127.

Reinherz, H. Evaluating programs of primary prevention: How can we know if they make a difference? In M. Nobel (Ed.), Primary prevention in mental health and social work. New York: Council on Social Work Education, 1981. (ERIC Document Reproduction Service No. ED 214 423)

Report of the task panel on prevention, President's Commission on Mental Health, Vol. 4, Washington, D.C.: U.S. Government Printing Office, 1978, 1822-1863.

Riley, B. E. Teacher stress: A workshop approach. Weatherford, Ok.: Southwestern Oklahoma State University, 1981. (ERIC Document Reproduction Service No. ED 212 607)

Rosenthal, A. K., & Scott, D. S. Four considerations in using imagery techniques with children. Journal of Behaviour Therapy & Experimental Psychiatry, 1977, 8, 287-290.

Rossman, H. M., & Kahnweiler, J. B. Relaxation training with intermediate grade students. Elementary School Guidance and Counseling, 1977, 11, 259-266.

Russ, W. R. The impact of teacher inservice education for the implementation of elementary guidance services and its relationship to selected organizational variables. (Doctoral dissertation, University of Cincinnati, 1976). Dissertation Abstracts International, 1976, 37, 1412B-1413B. (University Microfilms No. 76-21, 452)

Rutter, M. Fifteen thousand hours: Secondary schools and their effects on children. London: Open Books, 1979.

Sapp, M. E. The effects of participation in an affective education program on selected aspects of creativity. Unpublished doctoral dissertation, Ohio State University, 1975.

Schmuck, R. A. Process consultation and organization development. Professional Psychology, 1976, 7, 626-631.

Scriven, G. H., & Baldridge, J. E. Parent-Day care center communication. Program to Train Day Care Workers in the Rockford Region, 1982. (ERIC Document Reproduction Service No. ED 219 144)

Shechtman, A. Age patterns in children's psychiatric symptoms. Child Development, 1970, 41, 683-693.

Smith, D. L., & Muir, M. F. How to ruin an affective education program. Journal of Clinical Child Psychology, 1976, 5, 25.

Sparks, D., & Hammond, J. Managing teacher stress and burnout. Reston, Va.: American Alliance for Health, Physical Education, Recreation, and Dance, 1981. (ERIC Document Reproduction Service No. ED 200 522)

Stein, M. L. Therapeutic initiatives with inaccessible preschoolers. Journal of the American Academy of Child Psychiatry, 1976, 15, 385-394.

Stone, N. W., Pendleton, V. M., Vaill, M. B., Slatin, M., Mitcham, C., & Georgette, F. Primary prevention in mental health: A Head Start demonstration model. American Journal of Orthopsychiatry, 1982, 52, 360-363.

Stufflebeam, D. L., Foley, W. J., Gephart, W. J., Guba, E. G., Hammond, R. L., Merriman, H. O., & Provus, M. M. Educational evaluation and decision making. Itasca, Ill.: Peacock, 1971.

Tasch, R. J. Guidance at the preschool level. In G. D. Mills (Ed.), Elementary school guidance and counseling: An introduction through essays and commentaries. New York: Random House, 1971.

Tauss, V. The teacher as counselor in school systems in transition. Bayside, N.Y.: Queensborough Community College, CUNY, 1980. (ERIC Document Reproduction Service No. ED 201 918)

Torrance, E. P., & Phillips, V. K. Development of egocontrol through creative activities. Gifted Child Quarterly, 1972, 16, 271-274.

Wax, J. A mental health preschool program: Helping preschoolers with emotional and behavioral problems. Columbia, Missouri: Mid-Missouri Mental Health Center, 1971. (ERIC Document Reproduction Service No. ED 192 933)

Wittmer, J., & Myrick, R. Facilitative teaching: Theory and practice. Pacific Palisades, Calif.: Goodyear, 1974.

Wolman, B. B. Children's fears. New York: Grosset and Dunlap, 1978.

Wolpe, J. Psychotherapy by reciprocal inhibition. Stanford, CA.: Stanford University Press, 1958.

Worzbyt, J. C. Elementary school guidance: Program planning, organization, and implementation. Harrisburg, Pa.: Pennsylvania State Department of Education, 1978. (ERIC Document Reproduction Service No. ED 163 361)